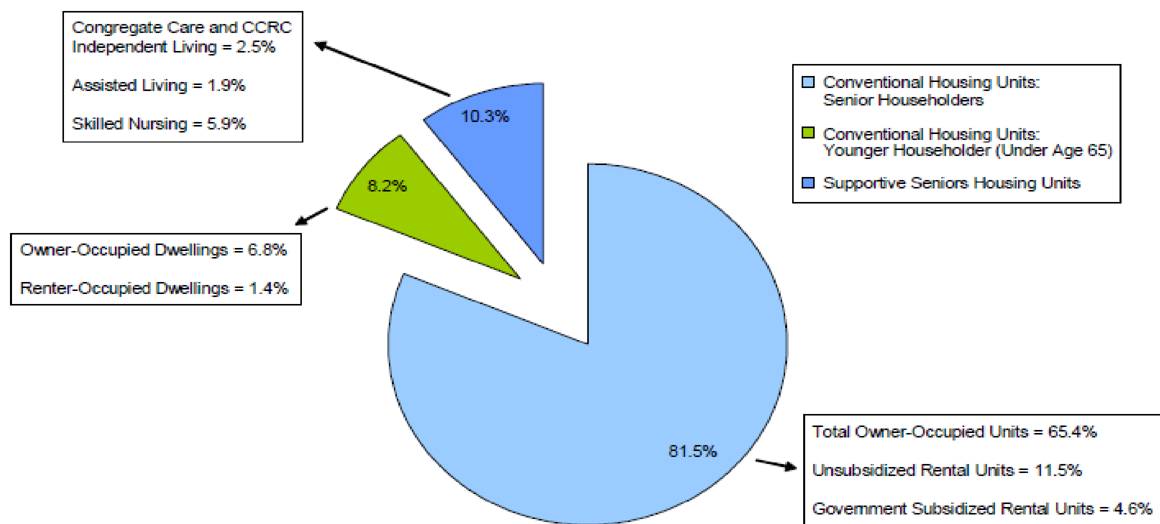
Imagining the Future for Continuing Care Retirement Communities

Continuing Care Retirement Communities (CCRCs) offer wonderful advantages for older people. There is a community of peers that can avoid the isolation that is too often the lot of those aging and the elderly. It is effective and efficient to have health services available nearby on the campus 24 hours a day. The range of amenities and services contributes to a relatively carefree existence, freeing seniors to pursue interests that they may have deferred during their younger years. The list goes on and on.



Why then isn't CCRC living the first choice for all? Today only 2.5% of those eligible choose the CCRC option. Clearly the CCRC industry is not able to get its

message out. This paper explores alternatives that might lift the profile of integrated living for the elderly and suggests changes that might make the CCRC product more attractive to more of those who are eligible.

How We Got Here.

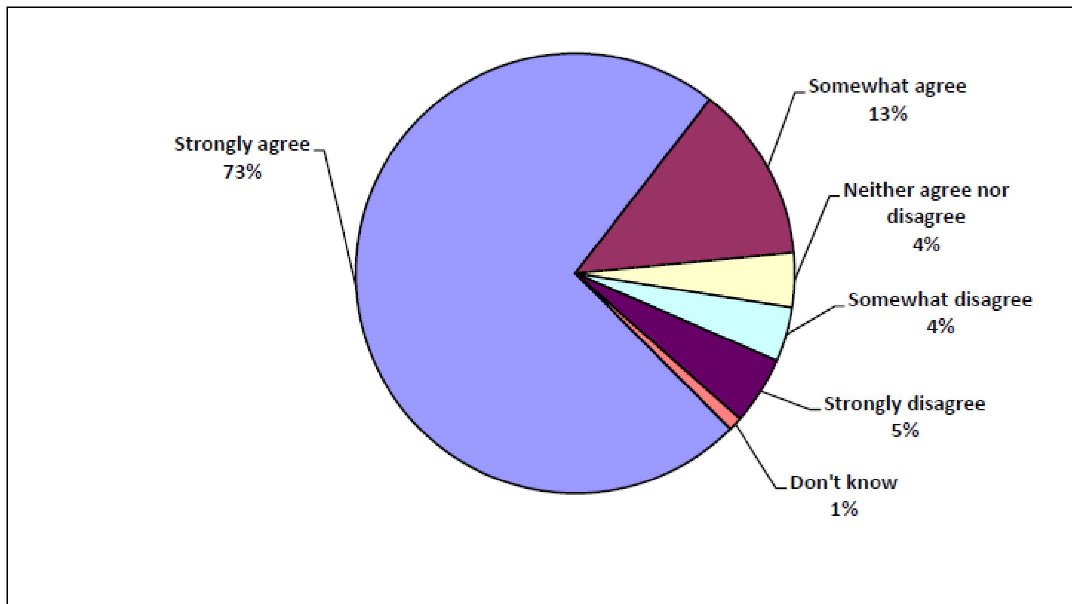
History, tradition, and conventional thinking have been the hobgoblins that seem to have inhibited the senior housing industry from reinventing itself to be attractive as the future of aging, instead of something that most seniors resist or come to reluctantly. The result is that most people strongly agree that they would really like to stay in their current residence for as long as possible (see chart on next page).

There are limitations that make it difficult to draw conclusions beyond mere impressions from the data in the chart that follows. The respondents' current residence may be a Continuing Care Retirement Community (CCRC) and they may be happy living there. Or people may interpret "as long as possible" to mean until I need assisted living, which would mean that people living in single family homes, or in active living communities, or just in an apartment complex serving the general population, might view independent living in a CCRC as no more than an attractive alternative to assisted living residence or to confinement in a skilled nursing facility. Though the study is flawed the result seems clear. People fear institutionalization if they leave home for a congregate living environment.

Many in the industry share this view. The nonprofit CCRC industry had its origins in the observation that people were apt to need increasing care as they aged and

Figure 1
Level of Agreement: Statement One

What I'd Really Like to Do is Stay in My Current Residence for as Long as Possible
(n=985)



Source: Home and Community Preferences of the 45+ Population, November 2010

Source: Home and Community Preferences, p.3[1]

that retired church and charitable workers with limited means could benefit from having a retirement home where they could invest what assets they had and be assured that they would be kept in residence, sustained, and cared for over the balance of their lives.[2] This was a charitable model that depended on donations to make up the shortfall between the assets that dedicated charitable workers were able to accumulate for retirement and the cost required to sustain them. In

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[1] http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf, p.3, accessed September 4, 2012
[2] http://www.healthlawyers.org/Events/Programs/Materials/Documents/LTC12/papers/EE_maag.pdf accessed September 4, 2012.

such a context there was little need for accountability to the beneficiaries. They were simply the recipients of the charity and good will of the community.

Revenue Ruling 72-124[3], issued by the Internal Revenue Service (IRS), allowed an expansion of that charitable model to include people who had sufficient assets to provide for their own retirement. The IRS then superseded its previous holding that, "Providing for the special needs of the aged has long been recognized as a charitable purpose for Federal tax purposes where the requisite elements of relief of distress and community benefit have been found to be present."

With Revenue Ruling 72-124 the IRS ruled that charitable status no longer needed to be "conditioned, in effect, upon whether an organization relieves the financial distress of aged persons by providing care and housing for them on a gratuitous, or below cost, basis," but that the aged as a class are "highly susceptible to other forms of distress in [the] sense that they have special needs because of their advanced years." Therefore, merely providing housing for the elderly regardless of means is considered a proper nonprofit activity by the IRS as long as specified conditions are met.

This is the context in which the nonprofit CCRC industry operates today. The older, longer serving executives entered their careers while CCRCs were still viewed as a traditionally charitable, donor supported activity often evolving from religious sponsorship. Many executives still cite training in ministry as their

[3] http://www.irs.gov/pub/irs-tege/rr72-124.pdf accessed September 4, 2012.

primary qualification for leadership. Masters of Divinity are as common in the executive suite as are Masters of Business Administration or their equivalents.

Thus, an industry that began as a charitable activity to care for those who were financially needy has evolved to be an industry that has a high end product serving those wealthy enough to afford it. Marketing has supplanted admissions as the contact between a CCRC and a prospective resident.

It can be daunting to move into a community knowing that this is to be your last home. It can come as a surprise for many, though, when they learn that they are committed to a CCRC for life while the staff who exercise the ownership authority are only committed until a better employment offer comes along.

What is the Challenge?

Clearly the challenge isn't that people reject the idea of living with others. Many older people choose to live in active living adult communities, typically restricted to those 55 and over. Others live in naturally occurring retirement communities, which tend to be neighborhoods in which the residents have aged together and have now reached collectively their elder years. The Village Movement has allowed older people to join together for common support. Senior Centers have proven to be popular oases for the older population and the congregate dining facilities often situated there tend to be full at lunchtime on most weekdays. PACE (Program of All-inclusive Care for the Elderly) programs bring older people of otherwise underserved socioeconomic means together for communal support.

Seniors are no different from younger people in their enjoyment of company and collective activity.

Consider the typical CCRC proposition for a moment. By reflecting on what a CCRC is we may find the resistance points to the concept and by identifying the resistance points we can have an opportunity to suggest changes to overcome them. The scientific method suggests that when an answer to a question isn't self-evident, then it's best to describe the phenomena in as clear and detailed a fashion as possible, since sometimes the perplexing answers lie hidden in the data. This works for business challenges as well as for abstruse scientific matters.

First, there is no trustworthy definition of what constitutes a CCRC. One person may be attracted by the idea that a single financial commitment covers all the contingencies of aging, only to find that the CCRC of choice doesn't offer an inclusive contract. The CCRC industry likes to repeat a saying that, "If you've seen one CCRC, you've seen one CCRC,"[4] which is taken to mean that there is no commonality among or between CCRCs. That is confusing to the marketplace. People come to understand that there can be no assurance that the term CCRC has any reliable meaning.

Second, partly as a result of the lack of uniformity in what constitutes a CCRC, residents in some CCRCs may be disappointed in what they experience after they make the move. People may move in, imagining that their needs will be provided for over their remaining lifetime, only to find that is not the case and that they

[4] See for instance https://www.elderlawanswers.com/elder_info/retirement-living.asp accessed September 4, 2012

will be charged for all care they receive. Or, they may learn that their CCRC is only licensed to provide some care, but not all care that they may need, so they may be precipitously transferred late in life to an external facility where they are unknown and have no friends. As residents become aware that there is no "normal" and that they've bought into something that isn't all that they imagined it to be, their disappointment is relayed to those who have yet to make the move, and that perception impedes acceptance.

Third, the very name embraces "Care" and "Retirement", both of which may be concepts that are unappealing to an active person in their 60s or 70s who envisions many years of productivity and enjoyment still to come. They may be thinking of leaving their employment, or they may already have given up active employment, but they are unlikely to think of themselves as retired much less needy of care. This leads to an impression that a Continuing ***Care Retirement*** Community is little more than a less acute form of assisted living or an assisted living environment in which an active spouse can continue to live comfortably with a partner of many years who has become less able.

Fourth, most CCRCs are owned by provider organizations, many of which are nonprofit providers. Many prospective residents are living in homes that they own. The opening proposition for an entrance fee CCRC is that a prospective resident agree to give up ownership in a home in exchange for an investment in a CCRC contract. Unlike a home which may pass to one's heirs, all value in a CCRC contract – after a guaranteed refund period – expires with the end of residency, i.e. the resident's investment defaults fully to the owning CCRC. Not only that but

the investment in a CCRC contract does not qualify for the same protections in Medicaid and elsewhere that come with home ownership. This proposition, the lack of resident ownership, is a formidable hurdle for CCRC operators to overcome.

Recently, there has been a trend to offer "refund" contracts promising to return 50%, 80%, or 90% of the entrance fee to a resident who moves or to the heirs of a resident who dies. But many of these "refund" contracts come with a catch. The catch is a contingent qualification that refunds are only paid when the residential unit is re-occupied by a successor resident and then often only to the extent of the proceeds from the re-occupancy.

This creates a cascade in which all or part of entrance fees from residents after the first are used to pay refunds to their predecessors. Because, as the American Institute of Certified Public Accountants (AICPA) has argued, "…the CCRC's own funds will never be used to make the refunds to the prior resident; instead, the CCRC is effectively facilitating the transfer of cash between the successor resident and the prior resident,"[5] the amount that is subject to refund is taken into revenue by the CCRC as earned.

As one might expect, offering a refund benefit that is to be paid by another (the subsequent resident) is attractive for CCRC operators and their marketing. The CCRC is able to spend the money and promise to refund it also. This creates a

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[5] http://www.fasb.org/cs/BlobServer?blobkey=id&blobwhere=1175823803805&blobheader-=application%2Fpdf&blobcol=urldata&blobtable=MungoBlobs, p. 5, accessed on September 13, 2012.

dependence on ***perpetual*** existence of the CCRC which calls into question the integrity of this “refund” model.

What’s to be done?

It’s easier to discern and describe the challenges than it is to suggest potentialities, much less to elaborate on how they might be put into place or to predict how they may be received by the public. Hence, this section is intended to be thought provoking, and it is expected that new materials will regularly be added to include new concepts that may be overlooked here and to expand on concepts here to add clarity to what is suggested.

Let’s start with ownership. Many prospective CCRC residents own their own homes and have to sell those homes to raise the funding for the entrance fees. The entrance fees often – almost always with the nonprofit model – provide equity capital to the sponsoring CCRC enterprise to allow it to own the residential facilities. In short, home owners frequently exchange their ownership equity for no more than a license to occupy a CCRC unit and to receive contracted services which may be altered by the provider through revisions to the Resident Handbook.

The resident’s home equity is used to provide equity capital to the collective enterprise, the CCRC operator. The resident has no stake and no say by right in the CCRC other than those in the operator’s unilateral contract. The CCRC operator, in turn uses that equity capital to enable it to develop and own the

CCRC property. Thus, many residents are lured into selling their homes to finance a replacement home that someone else owns and runs.

This leads to one possible conclusion that paucity of resident ownership opportunities may be a challenge inhibiting more extensive CCRC residency. Active living communities thrive offering ownership without care. Trading a home for a CCRC apartment can seem like institutionalization.

It can be disconcerting for people, who have enjoyed the self-determination and freedom of home ownership, to learn that the staff of a CCRC works for the provider rather than for the residents. Hence, creative solutions to allow resident ownership within the CCRC model offer the prospect of improving the attractiveness of CCRC living and of providing tax and other benefits. These benefits are not possible with the nonprofit owned CCRC which is the prevalent model today.

Over time we can work to develop practical options that can facilitate ownership and allow the potentiality for today's provider-owned CCRCs to convert to resident ownership while retaining the plusses of today's CCRC concept. The rapid turning of apartments at death is essential for the smooth financial working of a CCRC and some ownership concepts interfere with this practical need, though other resident ownership models allow more flexibility.

The prevalence of nonprofit organizations as owners of CCRCs is another challenge though that is a challenge that can be economically and financially

evaluated. An ownership model opens up funding sources and resident tax and other benefits that are not available with nonprofit ownership and management.

The absence of any standardized definition for a CCRC can be bewildering to people exploring the possibility of moving to a CCRC. It is desirable therefore to define a CCRC in the most encompassing terms, and to allow people to opt out of services that they don't need or that they don't desire. For this purpose a CCRC would be all-inclusive community for which an entrance fee and a single recurring fee, generally monthly, covers virtually all costs of residence regardless of care costs, and cost for meal options, television services, activities, telephone, utilities, and other amenities that may be incurred.

This approach could empower residents to make responsible, knowledgeable decisions within a context of full disclosure. Of course, a CCRC can be a luxury property or a more basic offering, and that need not be formally disclosed, since the physical characteristics of a particular community are self-evident even to a casual visitor.

Contract rigidity can also be a factor inhibiting the CCRC industry from thriving as the active living industry has thrived. The CCRC industry, through its nonprofit representative association, LeadingAge (earlier known as the American Association of Homes for the Aging and, later, as the American Association of Homes and Services for the Aging), has categorized contract types as though a typology lends credence to the variety of practice. The effect has been to lead

CCRC operators into believing that single option, or minimal option contracts are the norm.

This need not be and the absence of contract uniformity can be misleading to the public and lead to a sense among some residents after move in that the actual product provided is less than what they expected. Of course, residents should carefully scrutinize the contract and reject residency in communities with excessively limited or unilaterally worded contracts, but that resident sophistication is not what anecdotal evidence suggests happens in practice. Many residents, perhaps most, find contract review daunting – or they choose to overlook the warnings from their attorneys and financial advisors – so they enter into the contracts given to them without a full understanding of all that is contained therein.

This lack of consistency between the CCRC provider offerings and resident understandings suggest a need for regulatory oversight, but there is no uniformity of regulation from state to state and most regulation of contracts and finances is either nascent or nonexistent. At the same time there is an excess of regulation that inhibits the CCRC product from being as meaningful a response to the challenges of aging as it might be.

Health and safety regulation tends to be reactive and to require a standard of zero tolerance which makes it difficult, if not impossible, for facilities to give residents freedom of action, which is the essence of the human experience, without the facility's incurring "deficiencies" which impact a CCRC's reputation in

the larger community. In other words, if a provider allows the residents freedom, then the provider may be cited for putting the residents at risk. This inspection-driven perfectionism is contrary to simple human dignity.

Imbalance between the needs of the aging population served and the inconsistent regulatory restrictions placed on CCRCs suggest a need for regulatory review and reform. It is clearly desirable to develop national uniform standards for what constitute constructive and salutary regulation. Individual states would then be free to adopt the national standard or to use it as a guide in crafting their own approach to this promising industry for the aging and the elderly.

Management selection and development also needs some thought. The historical charitable model of a CCRC was a paternal model in which wise, caring leaders provided for needy people who were no longer as capable of providing for themselves as they once were. With a more empowered resident base this care orientation can become demeaning and condescending. Moreover, skills of care and tolerance are not the same skills as the analytical and financial skills needed for sophisticated capital and risk management undertakings. Modern management concepts such as Six Sigma and networked vs. hierarchical organizations seem foreign to the nonprofit world that is dominant among CCRC provider enterprises.

Related to management questions there are other questions that need thought. For instance, is a multi-facility executive group more likely to put enterprise interests before contract fulfillment and the welfare of the residents the

organization serves, or vice versa? Is a manager or executive director who lives on the premises more likely to respond effectively to residents than an absentee manager who views the CCRC as little more than a workplace? Should upscale nonprofit CCRCs provide donor supported funding for selected needy people, who otherwise could not afford to move in to a CCRC, like the charitable mission to maintain church and other workers in retirement that many once had? Does employee recognition through tipping and other gratuities improve performance and attract more committed employees or does tipping bias employees toward favoring more generous residents? While these may be interesting questions, they are beyond the scope of this paper.

This high standard of professional judgment calls for more than mere academic degrees. It is unlikely that the academic world is sufficiently disciplined in its award of credentials to provide the leadership selection track that is desirable for an industry with such a high stewardship calling. Hence, qualification standards may need to be developed independently from the teaching resources that can help aspirants to meet that standard.

Questionable qualification standards for senior and developmental managers has resulted in a crude pricing and reserving structure, but it is doubtful that the public has the sophistication to grasp the resulting unfairness. A more refined approach to the underlying stochastic structures of an aging population could foster greater equity and that might enhance the stature of the industry. One need only cite the confiscatory pricing standard that is common in the industry for internal, inter-unit transfers to see the lack of equitable understanding.

Also, higher managerial insights would allow CCRCs to match pricing and reserving to the services provided. This would engender greater assurance that needed funds would be available to pay for promised services as they come due. A trusting public typically looks to government oversight to ensure that complexities like these are managed in the public interest and that the managers work to serve those in whose employ they work. Still, integrity and competency in management are not qualities that can be governmentally mandated or required by outside overseers.

There are also questionable value judgments that have been codified into laws for the whole nation and that affect the quality of life of CCRC residents. For instance, the Older Americans Act of 1965 declared aging in one's home to be the national standard. Is that standard the best choice for our nation or might a congregate living option be a desirable alternative for those who don't prosper with solitude and isolation?

As another example, HIPAA (the United States Health Insurance Portability and Accountability Act of 1996) has been applied to prevent health providers from providing information about those in their care. This means that residents in the close knit, intimate circumstances of a CCRC often awake to find that one of their resident friends has disappeared and they are given no understanding of where the friend has gone. It may be that the missing resident was transferred involuntary, though for the resident's own good, to another facility that has a license to provide the care that the missing resident needs. But for the residents

who are left behind it's reminiscent of the "disappeared" in Chile when the Pinochet regime simply "disappeared" its opponents. That can unleash fear in a vulnerable CCRC population.

Then there's the Federal requirement that government programs only reimburse for a semi-private room in a skilled nursing facility. That can be an unacceptable diminishment in quality of life for people who have valued their privacy and dignity all their lives. A simple anecdote will show the unintended consequences of this Federal cost-saving measure. A man was recently transferred to the skilled nursing facility from assisted living. He looked around the spare room, with little more than a television, no DVD and limited channels, a single chair, and a hospital bed, and then he looked over toward the adjoining space occupied by a stranger he had never met. "Is this to be my home now?" he asked plaintively.

His visitor went to check and got the response that "They're no longer able to provide you the care you need in assisted living so you will be here with us from now on." The man, a physician who had brought more than 3,600 babies into the world, then said, "As a physician I know what I must do," so he stopped eating and drinking and he died within ten days. This man, who had given his life in service to others, ended his days by his own volition rather than endure the humiliation and the loss of dignity and privacy that is required of those nearing the end of their lives in skilled nursing facilities.

There is much work to be done to make life more endurable for our frail and vulnerable elderly some of which is beyond what we can now contemplate.

NaCCRA though is firmly committed to its mission of educating current and prospective CCRC residents, the providers who serve them, and others to consideration of these matters so that human dignity can be upheld and nurtured in our nation.

Where We Stand.

The integrated continuum of care model, which is the ideal toward which the CCRC concept trends, is the most promising approach to addressing the challenges of age. Up till now the CCRC industry has only been able to serve a negligible proportion (less than 2.5%) of the total population of those who are eligible for residency. That larger eligible population is comprised generally of those over age 60.

Many people in this demographic segment pride themselves on remaining active and fully engaged until the time comes when they are unable to continue without assistance. The ideal inherent in the CCRC concept allows them to fulfill this dream. They can continue to function as fully independent people with the assurance that they are backstopped by the availability of services when, and as, they need them. That is an ideal to be nurtured and fostered.

To gain the benefit for the nation of this promising model the regulatory and managerial preconceptions affecting the industry need fresh thinking. The value to be gleaned is great for those who undertake that challenge.

-- Jack Cumming, September 27, 2012