GEORGIA STATE HEALTH PLAN
COMPONENT PLAN

CONTINUING CARE RETIREMENT COMMUNITY (CCRC)
SHELTERED NURSING FACILITIES

HEALTH STRATEGIES COUNCIL
AND
DEPARTMENT OF COMMUNITY HEALTH
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TABLE OF CONTENTS

PREFACE

This Component Plan is a product of the Health Strategies Council and the Georgia Division of Health Planning which are funded through and operated within the authority of O.C.G.A. 31-6-1, et seq.

The purpose of the Plan is to identify and address health issues and recommend goals, objectives and system changes to achieve official state health policies.

This Plan has been produced through an open, public participatory process developed and monitored by the 27-member Governor-appointed Health Strategies Council. The Plan is effective upon approval by the Governor and supersedes all related sections of previous editions of the State Health Plan and any existing related Component Plan.

For purposes of the administration and implementation of the Georgia Certificate of Need (CON) Program, criteria and standards for review (as stated in the Rules, Chapter 272-1, 272-2, 272-3) are derived from this Component Plan. The Rules, which are published separately from the Plan and which undergo a separate public review process, are an official interpretation of any official Component Plan which the review function has the authority to implement. The Rules are reviewed by the Health Strategies Council (prior to their adoption) for their consistency with the Plan. The Rules, as a legal document, represent the final authority for all Certificate of Need review decisions.

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I. INTRODUCTION

A. Planning Process

Georgia's original Continuing Care Retirement Community (CCRC) - Sheltered Nursing Homes component of Georgia's State Health Plan was completed January 1989. Since that time, several events have occurred which led the Health Strategies Council (HSC) and the Agency to reevaluate the Plan and the related CON Rules. First of all, the retirement housing market has experienced many changes and developments over the past decade. Secondly, in the 1990 General Assembly, Georgia Law Title 33, Chapter 45 governing continuing care providers and facilities was passed. This law requires that a CCRC obtain a Certificate of Authority before it can operate and specifies provisions which a CCRC must meet with regard to annual reporting requirements, disclosure to potential residents, financial information and types of agreements.

As a result of these changes, the HSC requested its Long Term Care Technical Advisory Committee (LTC-TAC) Residential Care Resource Group to study and report on the current Continuing Care Retirement Community - Sheltered Nursing Homes Plan and to make recommendations. The recommendations identified areas of concern, particularly restrictive financial requirements and the need to evaluate the need ratio of nursing facility beds to independent living units.

This Plan addresses these issues, adds to the base of knowledge regarding CCRCs, and encourages open communication about how to best address the trends and issues involved in the future.

B. Care Continuum

The Strategies Council and its LTC-TAC and Resource Groups have spent a considerable amount of time defining the array of long-term care services and the settings in which these services can be delivered. The array of settings includes Community, Home and Residential, with emphasis placed on the linkage among all of the settings and the services provided in each.

The design of the array includes developing the governing principles for an effective long-term care system.

The basic premises covered in these principles include the following:

*Consumer-centered system

*Consumer choices with the right to take considered risks

*Maximum functional independence for consumers

*System visible to potential users

*A flexible and creative array of services provided in a variety of settings

*Needs assessment as an essential part of the system

*Coordination of services and care management

*Effective quality control, enforcement and training

It is the intent of this Plan to support the development of a long-term care system, including nursing facilities in retirement communities, which embodies these principles and which takes into account the factors which influence access to the system.

II. OVERVIEW

A. Trends and Issues

The steady growth in households age 75 and older, coupled with the greater likelihood of impairments with advancing years, suggests that a broader mix of supportive housing options and home care services will be needed to help maintain maximum functional independence of those in the oldest age groups. (Scruggs, 1995) Rapidly during the past two decades, retirement housing has emerged as a distinct and specialized industry, which has experienced many changes and developments. While non-profit organizations (having their roots in religious and fraternal organizations to provide comprehensive care for their aged members) have remained strongly entrenched, the players have expanded to include a variety of for-profit organizations. Although most facilities operating today are still structured with endowment (entrance) and monthly fees, the numbers of rental and equity (condos/coops) models are increasing as new facilities open. From development, through financing, design, and marketing, the experience of the past has provided a baseline for the innovation and experimentation now occurring in retirement communities. As a major component of the nation's long-term care delivery system, residential care facilities and boarding homes house more than one million people. (Tilson, 1990) Indicative of these trends is the fact that by 1990, 35 states, including Georgia, had passed legislation governing CCRCs, seventeen of which are regulated by the State's Department of Insurance. (Brecht, 1991) The American Association of Homes and Services for the Aging (AAHSA)and Ernst and Young National Continuing Care Data Base reports that there are over 1,000 CCRCs throughout the United States.

CCRCs are a unique type of service industry, one that combines the elements of real estate with those of hospitality and health care for a clientele whose needs change and grow as time passes. Seniors today are looking for beautiful surroundings, an active lifestyle and special wellness programs. For some organizations, this challenge was both unexpected and insurmountable. However, successful developers of CCRCs recognize that every senior has different goals, preferences, and constraints regarding their housing choices, as opposed to the stereotypical 'senior' citizen of the past. (Brecht, 1991)

Another way of describing a CCRC is to look at it from a business standpoint. M. Stroud Curran has described a CCRC as an amalgam of four businesses. First, it is a hotel that offers residential rentals, utilities, food and maid service. Second, it is a health-care facility that provides on-campus skilled nursing center or custodial care. Third, it is a social club that provides meeting and activity rooms for a variety of functions frequently under the total or partial supervision of management. Fourth, it is an insurance underwriter that offers health care services for the lifetime of its residents (Curran, 1983).

While many CCRCs were built as retirement communities with multiple levels of care, some grew from nursing homes, personal care homes or independent housing, which sometimes influenced the resulting balance of levels of care. Cited below is the average number of units/beds in a retirement community by level of care for the southern region and the nation for FY-90. (AAHSA, 1993)

Total	**Independent Living Units**	**Assisted Living/Personal Care**	**Nursing Facility Beds**
South - 351	236	45	83
All Regions - 315	197	43	90

Another trend to be considered is that managed care brings with it a concern for CCRCs that have not adequately prepared for managed care's entry into their markets. They may find their ability to serve their contract residents in the CCRC's nursing facility compromised. Residents enter a CCRC thinking that they are going to have security throughout their lives. However, the resident may end up going to the hospital. If they have purchased a managed care contract at some point, they may be unable to go back to their "home" CCRC because the managed care contract may specify sending that resident to another nursing home across town where the nursing facility care may have been negotiated at a lower cost. It appears that legislative action will be required to guarantee CCRC residents the right to return to their original "home" CCRC. Among the Association of Homes and Services for the Aging's (AAHSA) current year objectives, is promoting states' adoption of "return to home" legislation, which would require a managed care organization (MCO) (an HMO is one type) to refer a patient back to the "home" facility where he/she is a resident to receive covered services.

As stated earlier, new CCRCs or "look-alike" rental facilities have emerged on the horizon causing significant competition for CCRC residents and responding to the shifting attitudes of potential residents who wish larger living accommodations and more choices. In a recent AAHSA survey, 26 percent of the over 500 CCRCs responding reported offering potential residents a menu of different refund options and service packages. (Scruggs, 1995) It is interesting to note that applicants to rental facilities had the highest average age at entry (81 years) as compared to endowment type communities where the average age is 78 and at condominium projects where the average age at entry is 75.

B. Major Developments Reshaping the CCRC Industry

The Division of Health Planning (the Agency) and the Health Strategies Council (HSC) continually monitor and assess new developments in the life care and nursing home industries. Nationally and in Georgia, significant changes in health-care delivery make this the most significant period of change in human services since the development of Social Security in the 1930s and Medicare and Medicaid in the 1960s. Important recent developments include a radical reshaping of our health-care delivery system, a national commitment to reducing governmental expenditures and a generational shift in the elderly population, all of which force a rethinking of virtually every aspect of CCRC development.

One of the most dramatic demographic trends of the twentieth century has been the increase in the population who might be considered to be of retirement age. The growth in the proportion of older Americans above age 74 is particularly significant. In 1993, the 65-74 age group (18.7 million) was eight times larger than in 1900, but the 75-84 group (10.8 million) was 14 times larger and the 85+ group (3.4 million) was 27 times larger (Scruggs, 1995). While activities of daily living (ADLs) deficits vary widely from individual to individual, the data indicate that increased age frequently corresponds to increased difficulties with ADLs which corresponds to the need for a model of care offering the widest range of levels of care.

The last 100 years have brought with them a steady evolution and dramatic changes in science, medicine, technology, economics, sociology and a host of other environmental variables. A very important contribution to the market for retirement housing has been the vast improvement in the financial and economic condition of the elderly. In 1985, 75 percent of the elderly owned their own homes and 83 percent owned them mortgage free.

In many cases, the proceeds from the sale of a primary residence provides the up-front entrance fee into a CCRC. While change has been a constant for CCRCs, the closing years of the 20th century portend the arrival of new opportunities and challenges at a frequency and of a magnitude never before experienced (Scruggs, 1995).

C. Description of the Facilities

While there is no typical make-up of a CCRC, each offers some form of continuum of care which includes residential living arrangements and the availability of nursing facility services. A CCRC differs from other retirement options by providing a continuum of housing, services, and health care, centrally planned, located, and administered. For those communities providing nursing care, two circumstances determine the fee for such care. Direct entry into a nursing facility bed from outside the CCRC typically requires payment of a daily rate commensurate with the market rate for the area. Those who transfer to a nursing facility bed from the residential portion of the CCRC pay either a specific monthly fee or a daily rate. For communities that include health care coverage in their monthly fee, residents are able to declare a certain portion of the medical fees on their annual income tax statements as medical deductions.

The independent living units (ILUs) of a CCRC could range from studio apartments to individual cottages. The assisted living or personal care units can be either individual apartments or rooms. The nursing care beds consist of either private or shared rooms. In addition to the residential units and nursing beds, CCRC facilities have common areas and amenities which can be used by all the residents. All of the CCRCs have dining facilities and lounges or meeting rooms on their premises. Other amenities could include salons, barber shops, game rooms, fitness centers, chapels, libraries, and a host of other services.

The variety of continuing care agreements (or contracts) offered by CCRCs has increased over the years largely due to the advent of Medicaid and Medicare, rising health care costs, shifting consumer preferences and government regulations which have precipitated a myriad of contractual arrangements with residents. The most significant variation relates to the amount of health care coverage included and the types of payment plans and refund options offered. Extensive agreements cover most long-term health care without additional charges beyond the entry fee and/or monthly fees paid by residents. Modified agreements usually cover some

portion of long-term health care services. Fee-for-service agreements usually require residents to pay for the long-term health care services on an as needed basis. While the majority of CCRCs provide lifetime care in exchange for an up-front entrance fee and ongoing monthly fee, as stated earlier, some CCRCs provide an agreement that may be for a shorter period with no up-front entrance fee required.

Monthly fees are charged by all facilities. Typically, the greater the endowment (entrance) fee at a facility, the greater the average monthly fee. The various types of CCRC resident agreements are listed below:

Type A: All Inclusive Guarantees resident fully paid nursing care at no extra cost beyond the resident's monthly fee.

Type B: Modified Does not guarantee unlimited nursing care but provides a pre-specified number of days each year or during a resident's lifetime. Residents pay a daily charge for additional nursing care beyond the predetermined number of days.

Type C: Fee-For-Service Guarantees residents access to their nursing wing, but usually charges for each day of care.

Type D: Equity Models The condo/co-op model offers residents an equity opportunity to share in the ownership of the community and is an option for those looking for the benefits of owning real estate and the deduction of mortgage interest on taxes.

Continuing Care at Home

Continuing care at home is a new option. Based on research and development by Brandeis University's Health Policy Center and several Quaker organizations with extensive continuing care experience, continuing care at home springs from the desire of older people to stay in their own homes, but still have the assurance of long-term health care and support services. A care coordinator is available on a 24-hour basis, and varying levels of skilled nursing care and assisted living care are available when needed. Services may include registered nurses, home health aides, companions, homemakers, meals, emergency response, and home repair. Members usually pay an entry and monthly fee. Nationwide, just a handful of providers offer continuing care at home and, to the writer's knowledge, there is not yet a provider of "continuing care at home" in Georgia. (AAHSA, 1997)

D. Market Penetration Analysis

A major component of the requisite CCRC market study is the attempt to quantify the depth of the market, and

therefore, the level of risk associated with a project. The final result is a market penetration analysis which measures potential demand. However, in fact, it does not represent demand but is a tool that leads to the development of benchmarks to assess potential risk. It includes how the market is defined in geographic terms, in terms of the age and income of the population included in the qualified pool, and what an acceptable level of risk is, as measured by the market penetration analysis. Market area definition is one of the most critical components of market analysis for retirement housing communities. (Brecht, 1991)

Properly defining the geographic market area from which a CCRC community will draw most of its residents continues to be refined. However, what has emerged is that a CCRC community is mostly a 'neighborhood business'. Recent experiences of CCRCs corroborate this local market theory and it is further supported in the annual industry studies conducted by Laventhol and Horwath which contend that 50 - 55 percent of the residents of responding facilities had previously lived within 15 miles of the retirement community they selected. (Brecht, 1991)

Target age group has undergone the most substantial change in terms of market analysis. Some residents moved in while still in their sixties but they represented a distinct minority. The average age of entry was and continues to be in the mid-70s, not age 65, and is further supported by studies conducted by Laventhol and Horwath, The Longwood Group and Cwi and Associates. Currently, studies conducted by consulting firms rarely include households below the age of 70, and in some instances, consultants may limit their demand analysis to those households aged 75 and above. (Brecht, 1991)

Another significant factor, the insurance element inherent in the traditional lifecare concept, has been compared to a pension plan. Similar to a pension plan, lifecare communities receive revenues in advance of the cash payments required for meeting promised benefits. The payment of a CCRC entry (endowment) fee and recurring monthly fees is designed to advance-fund the cost of future health care for a resident. Improperly handled, this concept represents an area of substantial economic risk.

Penetration rate is an indicator of the demand for a CCRC within a geographic region and, therefore, of the expectation of the viability of a CCRC. It calculates the number of ILUs at the CCRC per the number of households with age and economically qualified individuals that are within the CCRC's primary target region and are eligible for residence at the community. It is assumed that the lower the penetration rate, the higher the

expectation for CCRC success, since there is a larger market to tap. (Scruggs, 1995) However, Brecht states that the level of penetration generally considered to be acceptable has increased, so that currently projects that involve penetration levels of five percent and even higher are judged to be supportable in terms of feasibility. (Brecht, 1991) While the radius analysis defines geographic boundaries, it does not consider factors that influence people's patterns of movement, which also must be known to quantify accurately. (Brecht, 1991)

E. Location, Setting and Size

As stated earlier, if any dominant theme has emerged from 20 years experience, it is that retirement housing is, for the most part, a neighborhood. (Brecht, 1991) Continuing care retirement communities are located throughout the nation with the majority located in Pennsylvania (48), California (27), Florida (19) and Virginia (18) as of 1991. In a 1989 AAHSA survey, more CCRCs were located in suburban settings than other settings. However, in a 1991 survey, more CCRCs list their location as towns or small cities and since there is an observed demographic trend toward older people moving to towns or small cities, the noted increase may support this conclusion. (AAHSA, 1993) Although the number of acres is quite varied, often depending on the location of the project and the type of facility, the average number of acres is 44. The average total gross square feet is 276,535. While retirement communities differ in many ways from traditional real estate developments, they are similar in their dependence on location in influencing prospective residents to consider a move. Most people choose to live in an area that reflects their socioeconomic status and values, and that allows them to participate in the community. (Brecht, 1991)

F. Quality

Quality in the CCRC industry is promoted by the Continuing Care Accreditation Commission (CCAC). Founded in 1985, it is the nation's only accrediting body for continuing care retirement communities and other retirement communities that meet its standards. The CCAC's accreditation program is based on the belief that accreditation promotes and maintains quality and integrity in the industry. The CCAC is an independent accrediting body sponsored by the American Association of Homes and Services for the Aging (AAHSA).

Also dedicated to enhancing the quality of life in CCRCs and promoting the interests of the industry are the two

major trade associations serving CCRCs, AAHSA (serving the non-profits) and National Association for Senior Living Industries (NASLI) (serving the for-profits).

III. SHELTERED NURSING FACILITIES IN GEORGIA

In Georgia, the CCRC industry is relatively limited. There are three CCRCs in Georgia as defined by the definition section of this Plan. It should be noted, however, that developers have recently shown a heightened interest in future development of CCRCs in both urban and rural areas of Georgia. Interestingly, two of the facilities are not Medicare certified while the third facility is. None of the three facilities is Medicaid certified. (AAHSA, 1997)

IV. GUIDELINES

A. Use of Guidelines

The following criteria and standards outline the guidelines for the development of and delivery of services in *Continuing Care Retirement Communities - Sheltered Nursing Facilities* in the State of Georgia as recommended by the Health Strategies Council.

B. Definitions

1. "A Continuing Care Retirement Community" (CCRC) is an organization which offers a contract to provide an individual of retirement status, other than an individual related by consanguinity or affinity to the provider furnishing the care, with board and lodging, licensed nursing facility care and medical or other health related services, or both. These services are provided for a minimum period of more than one year and may be for as long as the lifetime of the resident.

2. "Type A Continuing Care Retirement Community" (Type A CCRC) provides CCRC services at the same location for the life of an individual, including mutually terminable contracts, and in consideration of the payment of an entrance fee with or without other periodic charges. A Type A CCRC offers nursing facility care for a little or no substantial increase in monthly payments, except normal operating costs and inflation adjustments.

3. "Type B Continuing Care Retirement Community" (Type B CCRC) provides CCRC services at the same location for a period in excess of one year, including mutually terminable contracts, and in consideration of the payment of an entrance fee with other periodic charges. A Type B CCRC offers a specified amount of nursing facility care for little or no substantial increase in monthly payments except normal operating costs and inflation adjustments. After the specified amount of nursing care is received, residents pay either a discounted rate or the full per diem rate for nursing care required.

4. "A Continuing Care Contract" means furnishing, pursuant to an agreement, shelter, food, and either nursing care or personal services, whether such nursing care or personal services are provided in the facility or in another setting designated by the agreement for continuing care, to an individual not related by consanguinity or affinity to the provider furnishing such care upon payment of an entrance fee. Other personal services provided shall be designated in the continuing care agreement. Agreements to provide continuing care include agreements to provide care for any duration, including agreements that are terminable by either party.

5. "CCRC Sheltered Nursing Facility", for purposes of these rules, is a nursing facility which meets the definition of a nursing facility as defined by Chapter 272-2-.09(9) of the Rules of the State Health Planning Agency. A CCRC Sheltered Nursing Facility shall be for the exclusive use of residents of a Type A or Type B CCRC.

6. "Horizon year" means the last year of the three year projection period for need determinations for a CCRC sheltered nursing facility.

7. "Official State Health Component Plan" means the document related to the above-named services developed by the Agency, established by the Georgia Health Strategies Council, and signed by the Governor of Georgia.

8. "Planning area" for all sheltered nursing facilities means the geographic regions in Georgia defined in the "Official State Health Component Plan".

9. "Resident" is an individual entitled to receive continuing care in a Type A or Type B Continuing Care Retirement Community.

C. GUIDELINES

1. APPLICABILITY

These Guidelines apply to Sheltered Nursing Facility Beds in Continuing Care Retirement Communities as defined in this Plan. These guidelines distinguish sheltered nursing facility beds from general nursing facility beds which are addressed in a separate Plan.

2. AVAILABILITY

Standard 1 - Need:

A. Numerical need for a new CCRC sheltered nursing facility should be based on a ratio of one nursing facility bed for each five independent living units. The applicant for a CCRC Sheltered Nursing Facility, before making a determination to apply, should sufficiently demonstrate to the Agency via a market feasibility study that the potential market for CCRC independent living units in the proposed area to be served is based on a comprehensive, viable market feasibility study which takes into account factors such as, but not limited to, the number of households with age and economically qualified individuals that are in the CCRC's primary target region and are eligible for residence at the community.

B. Numerical need for an expanded CCRC sheltered nursing facility shall be based on a ratio of one nursing facility bed for each four independent living units provided that the CCRC's existing nursing facility has exceeded a high occupancy standard during the most recent year.

Rationale For Standard

New CCRC sheltered nursing facility beds should be approved only if there is demonstrated need in the proposed service area. However, as the elderly population continues to increase, it follows that so will the demand for CCRCs. Need should be determined by first determining the potential CCRC market in the area via a market feasibility study; and second, by determining the number of nursing facility beds. New CCRC communities are typically built in stages (to comply with typical financing requirements) and may take approximately three to four years depending upon individual circumstances. The nursing facility (or medical

care component) is generally the last stage to be built. Some communities may need to expand their existing sheltered nursing facility as the residents age and develop chronic conditions requiring nursing care.

For new construction, the Special Work Group appointed by the Long-Term Care Technical Advisory Committee's (LTC-TAC) recommended changing the existing ratio of 1:8 to 1:5 (nursing facility beds to independent living units) which is consistent with regulations in many other states and the relationships that have been a basic part of CCRC development as noted in current industry analysis.(Scruggs, 1996; AAHSA, 1993; Adams, 1997)

In defining the potential pool of applicants for CCRC independent living units (ILUs), one source calculates the number of ILUs at the CCRC per the number of households with age and economically qualified individuals that are within the CCRC's primary service area and are eligible for residence at the CCRC community. (AAHSA, 1995) Expected penetration rates are applied to this potential market taking into account competitive ILU services available at other facilities within the service area. The penetration rates provided in this source are shown below.

PENETRATION RATE

	Lower Quartile	Average	Upper Quartile
Penetration Rate	2.5%	5.5%	7.8%

Another literary source states that projects that involve penetration levels of five percent and even higher are generally considered to be supportable in terms of feasibility. (Brecht, 1991)

Another major factor used in estimating demand for CCRC residency is household income of the residents in the potential market segment. CCRCs usually employ some method to estimate the minimum income and asset levels of prospective residents to qualify them for residency. In the South, 37.9 percent of CCRCs reporting required an income twice the monthly fee (fee-to-income ratio) as the minimum income requirement. (AAHSA, 1993) Others require monthly income from 1.5 to 2.5 times the CCRC monthly fee. Statistics from the AAHSA show that in 1990 monthly CCRC fees ranged from $686.00 to $1,692.00 depending upon the type

of unit and type of continuing care agreement. Based on twice the monthly fee, an average household income ranging from $16,500.00 to $40,500.00 would be representative of the annual income requirement. (AAHSA, 1993)

A third factor in estimating demand is age of the potential market segment. Anecdotal data suggest that the average age at entry has increased over the last 10 years or so. (Brecht, 1991) The current data from AAHSA shows that, in the South, the average age at entry for all current ILU residents is 78.4. (AAHSA, 1993) Other sources corroborate this average entry age. (Brecht, 1991) For planning purposes, the assumption is made that using the 65+ population constitutes the major portion of the potential CCRC market. It is recognized that residents in the 65 to 75 age group at entry represent a distinct minority. However, using this age group (65+) provides consistency with the Agency's other plans relating to long-term care. For example, this age group is utilized by the Agency in planning general nursing facility and home health services.

Standard 2 - Use of Sheltered Nursing Facility Beds Exclusively for CCRC Residents

Sheltered nursing facility beds approved under these rules shall be used exclusively for persons who are residents of the CCRC, and who are a party to a continuing care contract with the facility or the parent organization and who have lived in a non-nursing unit of the CCRC for a period of at least 90 days. Exceptions shall be allowed when one spouse or sibling is admitted to the nursing unit at the time the other spouse or sibling moves into a non-nursing unit, or when the medical condition requiring nursing care was not known to exist or be imminent when the individual became a party to the continuing care contract. At no time shall the nursing facility beds be certified for participation in the Medicaid Program.

Rationale for Standard:

The purpose of a CCRC is to serve its residents by offering all levels of care at one site. Prospective residents may be reluctant to make a commitment to a CCRC if they are not confident that their health care needs will be provided on campus, rather than being transferred to another nursing facility. (ACTS, 1996) Therefore, it is the intent that Sheltered Nursing Facility Beds will be used exclusively to meet the needs of persons with whom the CCRC has continuing care contracts who have lived in a non-nursing unit of the CCRC for at least 90 days. Financial consideration paid by persons purchasing a continuing care contract shall be equitable between persons entering at the "independent living" and "domiciliary" (assisted living) levels of care. Traditionally, fund

raising events are held to subsidize this care.

Participation in Medicare and/or Medicaid programs can impact operating costs and fee structures, particularly in communities with more nursing facility beds than can be supported by contract residents. The results of a recent study of how many CCRCs participated in Medicaid revealed that only 14 percent nationwide were Medicaid certified. (Scruggs, 1996) Also, North Carolina and Pennsylvania do not permit Medicaid participation in the Sheltered Nursing Facility of a CCRC. Often a CCRC, particularly a non-profit, is committed to provide for the financial needs of its residents without reliance on government funding.

3. QUALITY OF CARE

Standard 1 - Licensure and Accreditation of the Sheltered Nursing Facility

A new or expanded sheltered nursing facility should provide evidence of intent to meet all appropriate requirements regarding licensure and accreditation as follows:

(1) Compliance with all appropriate licensure requirements and operational procedures required by the Office of Regulatory Services of the Georgia Department of Human Resources;

(2) No uncorrected operational standards in any existing Georgia general or CCRC sheltered nursing facilities owned and/or operated by either the entity, its affiliates, or its principals. Plans to correct physical plant deficiencies should be provided;

(3) No previous conviction of Medicaid and/or Medicare fraud by either the entity, its affiliates, or its principals;

(4) Provision of a plan for a comprehensive quality improvement program which includes, but is not limited to, procedures and plans for staff training and a program to monitor specific quality indicators and measure the facility's performance and patient outcomes accordingly; and

(5) Intent to meet accreditation requirements of the appropriate accrediting agency(ies).

Rationale For Standard

The facility and its staff must operate and furnish services in compliance with all Federal, State, and local laws and regulations applicable to nursing facilities. The Department of Human Resources, Office of Regulatory Services has established licensing requirements for nursing facilities.

Standard 2 - Authorization and Accreditation of the CCRC

The CCRC in which the new or expanded nursing facility is to be located should provide evidence of intent to meet all appropriate authorization requirements of the State Department of Insurance and of any appropriate accrediting agency(ies). The CCRC should furnish reports in such form and at such times as may be specified, which accurately and fully disclose it has met specified requirements.

Rationale For Standard

Georgia Law Section 33, Chapter 45 governing continuing care provider and facilities was passed in the 1990 General Assembly. This law requires that a continuing care facility obtain a Certificate of Authority before it can operate. The law includes specific provisions for annual reporting (May of each year), disclosure, financial information and continuing care agreements which a CCRC must meet.

Recognizing that quality in the CCRC environment goes far beyond health-care delivery, the CCRC industry formed the Continuing Care Accreditation Commission (CCAC) in 1985. Accredited CCRC communities are required to meet industry-generated standards of excellence in four areas: health care, finance, resident services, and governance and administration. As managed care envelops the industry, accreditation will become an increasingly important means of differentiating and identifying communities where quality is emphasized.

4. FINANCIAL ACCESSIBILITY

Standard 1 - Health Care Fund or Insurance

A CCRC in which a new or expanded sheltered nursing facility is to be located should demonstrate the existence of a Health Care Liability Fund whose liability is documented by a relevant Actuarial Study and certified by a qualified actuary; or the existence of a Long Term Care Insurance Policy issued to individual residents; or a Group Long Term Care Insurance Policy issued to the CCRC for the coverage of all residents. An Individual or Group Insurance Policy must conform to all the requirements of Chapter 120-20-16 of the Rules and Regulations of the State of Georgia Insurance Department entitled "Long-Term Care Insurance Regulation". The period and scope of coverage must be identical to the period and scope of coverage in the

continuing care contract.

Rationale for Standard

The CCRC concept involves a large insurance effect. Traditionally, the entrance fee has been used to prepay benefits and expenses with extensive cross-subsidy among members of different age groups or similar ages but differing health care needs. Deviations from the expected expenditures have often contributed to poor CCRC financial status and in some cases to ultimate default. The requirement that CCRCs should establish a health care fund and subsequent annual actuarial updates is aimed at ensuring that health care is available when needed as promised in a continuing care contract. A health care Letter of Credit may be one component of the health care fund. "Qualified actuary" is used to mean a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the appropriate regulatory official of the domiciliary state. (Powell, 1988)

Long-term care insurance, as a private financing mechanism for long-term care services, is gaining ground. Connecticut is one state that offers incentives for the purchase of long-term care insurance. Long-term care insurance is expected to play a vital role in the future of CCRC contracts. If the policy is consistent with the provisions of a continuing care contract, the policy can become a viable tool in the financing of health care in a CCRC. It is suggested that the CCRC could assume the responsibility for collecting the premiums in order to maintain consistency in coverage of residents. The required annual reporting is aimed at encouraging conformance with this Standard.

5. INFORMATION REQUIREMENTS

Standard 1 - Data Collection

A CCRC in which a new or expanded sheltered nursing facility is to be located should provide the Agency with requested information and statistical data related to the operation and programmatic elements of the CCRC and the Sheltered Nursing Facility.

Rationale for Standard

Analyses are predicated upon accurate, consistent and systematically obtained information. An example would be an annual or semi-annual survey or questionnaire from the Agency from which numerous and varied reports can be formatted as well as ad-hoc questions. Uniform data on CCRCs allows more precise assessment of the ratios of services provided as well as of costs, trends, charges, access, marketing strategies, entry and service fees, growth patterns, and other elements important to future planning efforts.

V. GOAL, OBJECTIVES AND RECOMMENDED ACTIONS

GOAL

To ensure that Georgians have access to an integrated array of high quality long-term care services, including Sheltered Nursing Facility services and residential units, which is resident-focused, promotes maximum functional independence for residents, and includes elements that will enhance the future success of the facility.

OBJECTIVES

1. Assure that Sheltered Nursing Facilities in CCRCs are available and accessible to people in sufficient numbers and locations which are compatible with need.
2. Assure quality of Sheltered Nursing Facilities in CCRCs by considering compliance with appropriate licensure, accreditation, and authorization requirements for both the Sheltered Nursing Facility and the CCRC.
3. Ensure financial accessibility by providing a certified Health Care Liability Fund or individual Long Term Care Insurance policies or a Group Long Term Care Insurance policy to cover all residents of the CCRC.
4. Implement Certificate of Need (CON) Rules for CCRCs - Sheltered Nursing Facilities which are consistent with this Component Plan and approve CON applications accordingly.
5. Support research and demonstration projects which will promote a seamless, coordinated array of services on one campus based on the principles and models developed by the Health Strategies Council.
6. Collect data annually, and on an ad hoc basis, to maintain current, accurate information related to availability, quality, efficiency and effectiveness of services already in existence.

RECOMMENDED ACTIONS

1. Assess the present State law governing CCRCs, make recommendations for possible modifications, and work as a team to implement changes which will strengthen protection of potential residents of CCRCs while providing the flexibility needed by developers of CCRCs which will promote compliance with all rules and regulations.

2. As annual data is collected, assess the efficacy of existing and emerging CCRCs, as well as the operating research and demonstration projects, to enable the development of comparative benchmarks for Georgia.

3. Identify and track developing facilities within the State of Georgia.

VI. REFERENCES

ACTS, Informational Briefing for the Georgia Department of Insurance (March 1997), West Point, Pennsylvania.

ACTS, Correspondence of Recommendations, August 1996.

Adams, Karen. (May 1997), "Growth in the Non Profit Sector", Nursing Homes, Volume 46, No 5, Cleveland, Ohio.

American Association of Homes and Services for the Aging and Ernst and Whinney. Continuing Care Retirement Communities: An Industry in Action. Washington, DC: 1993.

American Association of Homes and Services for the Aging and Ernst and Whinney. Continuing Care Retirement Communities: Overview and Developing Trends, Washington DC: 1993.

American Association of Homes and Services for the Aging. Emerging Continuing Care Retirement Communities: An Analysis of Key Statistics, Washington DC: 1995.

American Association of Homes and Services for the Aging. The Consumers' Directory of Continuing Care Retirement Communities, Washington, DC: 1997.

Brecht, Susan B. (1991), Retirement Housing Markets: Project Planning and Feasibility Analysis, John Wiley & Sons, Inc., New York, N Y.

Ohio Philanthropic Homes, Housing and Services for the Aging, Association of, communication regarding "return to home" legislation, March 28, 1997.

Personal Interview with Linda Gowdy, Chair, Life care Community Council, Albany, New York: March 6, 1997.

Powell, Alwyn V., Tillinghast Company - Management Consultants and Actuaries, Letter to James Kahiga, November 9, 1988.

Scruggs, David W. (1995), Dare to Discover: The Future of Continuing Care Retirement Communities, American Association of Homes and Services for the Aging, Washington DC.

Scruggs, David W. (1996), Draft Copy, The CCRC Industry - 1996 Profile, American Association of Homes and Services for the Aging, Washington DC.

Tilson, David, (1990), Aging in Place, Supporting the Frail Elderly in Residential Environments, American Association of Homes and Services for the Aging and The Foundation on Gerontology.

Virginia House Bill No. 2870, Proposed by the House Committee on Corporations, Insurance, and Banking. Obtained from AAHSA.