



CONTINUING CARE AT HOME: EVOLUTION, INNOVATION, AND OPPORTUNITY

A Continuing Care at Home (CCaH) program is one way entrepreneurial senior living providers are seeking to help mold the future.

The growth of home-based and community-based services during the past several years has been fueled by the weak housing market, improved technology that allows seniors to have care delivered at home, and above all, seniors' desire to remain in their homes as long as feasible.

A striking number of "traditional" campus-based providers are offering home-based services to seniors. Some offer new approaches to delivering care in the home or extending campus services to the broader community. Others replicate existing services, but focus on new markets in an effort to extend their missions more broadly.

The *2012 LeadingAge Ziegler 100 Fact Sheet*, a study of the largest 100 nonprofit senior living organizations in the United States, notes the number of at-home programs offered by these organizations increased by 32 percent between 2010 and 2011. *Franchise Business Review* has identified private duty home care franchises as among the "hottest" in terms of growth and financial return. The *Patient Protection and Affordable Care Act* included many demonstration projects focused on providing home and community-based services and modified consumer financial qualifications for access to these types of programs. These innovative and successful demonstration projects are helping make the strategic case for re-imagining opportunities to serve the largest segment of the growing market for senior care services.

Clearly, there is no single type of at-home service that represents the only solution or opportunity. It would be a mistake to assume the estimated 90 percent of seniors who prefer to live at home will embrace a single product or approach. A Continuing Care at Home (CCaH) program is one way entrepreneurial providers are seeking to help mold the future — in most cases by building on core strengths that have been developed over time and balancing the demands of a new and distinct service line. Given the interest in this evolving field and the frequent questions we receive about these innovative programs, this white paper will explore the benefits, misconceptions, and challenges of CCaH programs.

OVERVIEW

At its core, a CCaH program is a life care membership program offering the same kind of services as a Type A continuing care retirement community (CCRC) to consumers who choose to live in a setting other than the traditional CCRC. In return for an entrance fee and a monthly fee, participants are covered by a comprehensive package of long-term care services designed to enable them to remain independent and live at home as their care needs increase. An initial screening of applicants is required, and only those not in need of services and with no degenerative diagnoses (such as Alzheimer's or Parkinson's) are

appropriate for the program. Access to services is typically related to a deficit in at least one of five to seven activities of daily living.

The package of services is designed to address the social, spiritual, recreational, and health needs of members, and is comprehensive in nature, often including the following:

- Care coordination
- Home inspections
- Annual physical
- Access to campus amenities and services
- Social and educational opportunities
- Emergency response system
- Homemaker and personal care services
- Home nursing
- Live-in services
- Meals
- Transportation
- Adult day program
- Assisted living and nursing home facilities
- Referrals for home maintenance, housekeeping, lawn care, etc.

Innovative technologies, along with traditional service options, support members in their homes for as long as possible. Some, but not all, CCaH programs offer members access to the amenities on campus, such as dining, fitness, and social activities. Most of the existing programs also offer a range of social programs to foster relationships and support among members. Services may be provided by sponsoring organization employees or by sub-contracted vendors that are credentialed to ensure quality operating standards.

Care coordination is critical to member satisfaction and program success. Each member is assigned a care coordinator who is typically available to meet him/her at the start of program membership. The care coordinator gets to know each member personally, and, as a result of developing a positive, trusting relationship, becomes a valued advocate when a member's health changes. It is the care coordinator who will regularly assess a member's health and functional status, recommend needed services, and obtain and manage those services on behalf of the member. The care coordinator will help alleviate the burden of care from families for their loved ones and, with the member's permission, can communicate regularly with family members.

Members may also receive referrals to a developed network of pre-screened, preferred providers of services that are not paid for by the CCaH program, such as home maintenance, lawn care, or housekeeping. Depending upon the excess capacity of campus departments, this referral network may be comprised of a combination of sub-contracted vendors as well as services provided and managed by the sponsor's campus departments, thus driving additional revenue to the sponsor/campus.

The pricing structure of CCaH programs is a life care model, offering a member a lifetime guarantee of care for a one-time entry fee and monthly fees that begin the first month of membership. Entry fees increase based on the age of a person when he/she joins the program. The monthly fees are designed to increase annually to reflect the overall operating experience and the cost of living, but typically do not increase as a member needs care, thus protecting a member from "spending down" assets.

Sound actuarial pricing is key when operating a CCaH program. An actuarial study should include:

- A clear definition of the package of services and their costs
- The criteria a member must meet to qualify for services
- A clear articulation of when entrance fees are refundable
- The cost of administrative staff and related expenses
- The daily cap on expenses
- Estimated future utilization of services

Usually, a 5 – 15 percent margin is included in the pricing formula, which serves as a "risk buffer" in the event of adverse experience. However, the actual amount should be based on the number of members anticipated and the contract design. While basic Type A contracts predominate, a consumer may be offered a choice of pricing options that may include:

- A variety of co-pays for future services
- Home care only
- Long-term care insurance (LTCi) policy credit
- Limited total life-time benefit amount
- Refundable membership fee

One program has designed a pricing approach that incorporates an entrance fee paid over time. This same program offers a variety of pricing options similar to LTCi, including several benefit period options, daily expense caps, and elimination periods.

CCaH programs have the potential to financially benefit the sponsoring organization's campus and its residents in many ways:

- An additional program spreads out administrative costs for shared services such as management, human resources, financial management, billing, and accounts payable and receivable.
- CCaH programs can increase occupancy of assisted living and nursing home beds (although this may be modest because effective care management protocols can provide substitute services in a member's home). Reimbursements are paid to the campus by the CCaH program at the private pay rate.
- CCaH programs tend to increase nursing home occupancy for Medicare Part A short-term rehab stays.
- CCaH programs provide rental payments for use of space and amenities.
- Program members increase the utilization of ancillary service lines such as home care, home health, and adult day care.
- A modest number of members may move from the CCaH program to independent living.

FREQUENTLY ASKED QUESTIONS ABOUT CCAH PROGRAMS

CCaH programs have existed for more than 20 years. While the early research was well covered by the field over the past decade, little has been written about the progress of the early programs and their subsequent development. Consequently, we frequently field questions about how these programs work.

FAQ one: Are CCaH programs just like long-term care insurance?

At its core, LTCi is about managing claims for the company. CCaH programs are about managing care for members. Some have suggested that a CCaH program essentially allows providers to offer an unregulated LTCi product. While most current providers use admissions underwriting methodology similar to LTCi and the actuarial firms used to price this product draw on LTCi data, what attracts most consumers is the tangible relationship between the member and the non-profit, mission-driven organization. In addition, a CCaH program provides intimate relationships with program care managers and comprehensive, flexible service packages.

FAQ two: Are actuarial projections accurate?

It is critical that the actuarial firm hired to price a CCaH program has a diversity of experience on which to rely when developing the pricing model. Because the

CCaH concept is fairly young, the actuarial firm must have experience with CCRCs, CCaH programs, and LTCi. The importance of LTCi data cannot be understated. LTCi companies typically offer a variety of policies and have longer and older policyholder data. This diverse experience helps to validate assumptions related to future utilization of services.

Bob Yee, principal and consulting actuary for DaVinci Consulting Group of Yardley, Pennsylvania, stated in a recent interview that his firm is not concerned by the lack of CCaH program data because of the depth of LTCi data that his firm uses. Yee said he understands the perceived risk regarding predicting future utilization for a fairly young product that has a large percentage of younger members.

"We feel we are well equipped to adequately price this product because of the size of our LTCi database, and the similarities that we see between CCaH members' and LTCi policyholders' utilization of services," explained Yee. "The main difference between the two products is that care management is provided on an ongoing basis for CCaH members starting from the initial enrollment, and only provided at the time of a claim for LTCi policyholders. The ongoing care management is essentially a 'pre-paid' service whose cost can be reasonably estimated."

Yee also said he recognized that the relatively small size of CCaH program data is an issue, but he believes that by tapping current CCaH experience and supplementing it with LTCi experience, reasonable assumptions can be developed.

FAQ three: What are the biggest risks in CCaH programs?

We believe there are three primary risks. The first is when organizations believe a market exists, when it doesn't. The second is the risk related to the integrity of the admissions screening process. The third is managing the delivery of services (resulting in expenses) to the contract. While all three link to the actuarial projections — they are, in fact, operational issues.

- Credible, objective market research is required. And, not every market will be large enough to support a CCaH program, nor will every market have consumers who are interested in this type of program. Early market share testing should incorporate the actual market share that existing programs have been able to capture and should consider the distinctions between those market areas. Statistically sound consumer research (which is more likely to be accomplished through telephone surveying than mail surveys)

is necessary, followed by focus group research to gather intelligence regarding price sensitivity, interest in services, and preferred pricing plans. A sponsor considering the development of a CcAH program must be willing to abandon the program if the market indicators are negative. While the financial risk may be significantly less than the risk accompanying the development of a facility or campus, the reputational risks deserve consideration. And steady enrollment of new members with the ability to reach a critical mass is important to ensuring a successful program.

- Admissions screening risk means that no matter how good the actuarial projections are — making decisions to admit members who don't meet the health and risk criteria will drive the program into a financial crisis. Experience shows that CcAH programs will reject (on a percentage basis) more applications for membership than a lifecare CCRC. And that's the way it should be. It is important to remember that all service expenses are incremental for a CcAH program and adverse selection can be detrimental to the organization's financial health.
- The third risk to consider is related to the benefits defined in the member agreement. The services and related expenses paid for by the CcAH program must be clearly defined in the agreement. Program management should think creatively when developing a service plan, however, the creativity must be kept within the confines of what has been priced by the actuaries. For example, if a program pays for items such as ramps and other home improvements for its members but these items were not included in the package of services priced by their actuaries, the long-term financial health of the program could be at risk.

CCRC Actuaries, LLC, of Baltimore, Maryland, currently provides actuarial services to 10 operational CcAH programs ranging from a program that has been operating for less than a year, to one operating for more than 15 years. CCRC Actuaries has developed CcAH utilization and cost assumptions based on the combined experience of their CCRC, CcAH, and LTCi clients. According to a recent interview with Dave Bond, managing partner of the firm, "The key focuses of CcAH management with respect to financial success are enrollment goals, underwriting standards, program administrative expenses, and health care utilization and cost. It is important that the management team constantly monitor all four components, because results will be different than expected. These are relatively small programs in terms of risk theory and risk management. But more importantly, the CcAH operator should

understand that adverse experience does not necessarily mean financial failure, as there is an array of potential remedies that can be implemented, including annual fee increases, and if necessary, administrative expense reductions ... just as CCRCs have done over the years."

FAQ four: How difficult is it to combine a CcAH program with a Program of All Inclusive Care for the Elderly (PACE)?

These models may appear to be similar, but the socio-economic status of their members differs greatly, and there are challenges in bringing these two groups together.

There may be some opportunity to integrate the care coordination function for PACE and CcAH, requiring less expense to manage both programs. To our knowledge, this integration approach has not been implemented anywhere yet, but we caution that the care management approach will need to be very different for these two programs. The benefits packages are different, member/participant expectations are different, and the socio-economic backgrounds are very different. Successful integration will require administrative and care management staff to be very sensitive to these differences, and be comfortable and skilled at managing accordingly.

FAQ five: Do CcAH programs compete with a traditional CCRC Campus for the same market share?

CcAH programs appeal to a distinct segment of the market — those who are passionate about staying home. We have seen no cannibalizing of the sponsoring campuses' wait lists. Our experience indicates that CcAH programs do not compete for market share with their sponsoring campuses, but actually increase brand awareness and ultimately have enhanced the marketing efforts of sponsoring campuses.

FAQ six: Do CcAH programs significantly boost occupancy in independently living, assisted living, and nursing home facilities?

We have not found the programs to be a successful strategy to dramatically increase independent living occupancy. A small number of CcAH members make the transition from the CcAH program to the campus as a result of the increased affinity to the campus that comes with CcAH membership. For example, when a spouse passes away, the remaining spouse may decide he/she does not want to stay home alone and begins the search for a retirement community campus. This member is more likely to move to the sponsoring organization campus because of the trust that has developed with the

CCaH program staff, and the familiarity with the campus that has come from access as a CCaH member.

Movement from the CCaH program into independent living on campus sometimes depends on the financial incentives offered to members. Pamela Klapproth, vice president of community outreach services and managing director of the Seabury at Home program in Bloomfield, Connecticut, said her program offers members 90 to 100 percent credit of their CCaH membership fee to apply to their entrance fee if they decide to move onto campus.

“This entry fee credit program was originally designed to provide security for people on our waiting list who could possibly be waiting years to move onto the campus,” said Klapproth. “We started offering the entry fee credit program in 2009. Since then, seven Seabury At Home members have moved onto campus. Overall, we find that most of our at-home members have different desires and interests compared to our campus residents in regards to where they want to live.”

Another sponsoring campus offers a rental option where members can move onto campus and keep their CCaH contract for future long-term care needs. The result was a small number of additional move-ins at a time when campus occupancy was falling.

It is important to note that contractual nuances such as these must be described to actuaries and included in the pricing calculations.

FAQ seven: Do current regulations provide enough protections for consumers?

Some have suggested that CCaH programs are unregulated LTCi products and as such, need a stronger actuarial component in addition to the regulations in place. The states that authorize CCaH programs by statute and/or regulation do so either through a structure that has been developed specifically to regulate such programs (e.g., Florida or Maryland) or consider CCaH programs to be continuing care providers under existing CCRC regulations (e.g., Pennsylvania and New Jersey).

As discussed earlier, LTCi is very different from CCaH programs. LTCi is focused on claims management; CCaH programs focus on care management. LTCi extends coverage to a large number of individuals; CCaH programs serve a smaller, select number of individuals — where personal relationships help moderate risk. If one believes that the current regulatory structure for CCRCs is adequate (as supported by the recent report by the U.S. Senate Special Committee on Aging, which did not recommend federal oversight but rather more vigilant

state oversight), then it is difficult to argue that CCaH programs deserve a higher level of regulatory oversight.

CCRCs and CCaH programs should always follow best practices related to both a preliminary actuarial pricing study and regular actuarial study updates to ensure that pricing and reserves are set at levels that fully fund liabilities.

On the other hand, if one believes that all CCRC regulation should have a more aggressive actuarial component — then the argument that CCaH regulation should have an actuarial component makes sense. However, no current research suggests that there is a greater failure rate for CCRCs in states without rigorous actuarial requirements. In fact, the unintended consequence of complex regulations may be to limit the growth of CCRCs (and by extension, CCaH programs).

“...individuals who proactively plan to finance care in the home have a lower probability of using facility care.”

FAQ eight: Do CCaH members use campus-based assisted living and nursing homes at the same rate as campus residents?

According to Carol A. Barbour, CEO of the first and oldest (22 years) CCaH program in the country, Friends Life Care, approximately 2 percent of the program’s 2,200 members are currently receiving services in an assisted living and/or nursing home — below the typical expectation for a CCRC of the same age. Bond of CCRC Actuaries said that assisted living and nursing home utilization for all of the firm’s CCaH clients is significantly less than the average utilization of these levels of care by their CCRC clients.

“In addition to analyzing individual CCaH programs, we have also analyzed how the CCaH experience compares to our six LTCi company clients,” explained Bond. “... The experience of these companies, along with the experience of our CCaH clients, indicates that individuals who proactively plan to finance care in the home have a lower probability of using facility care.”

There are a range of facility-based care arrangements among CCaH sponsoring organizations. Some only offer access to assisted living and nursing home care at their own campus. Reasons for this limitation include state regulations, an interest in controlling quality, and the belief that there is a market advantage in allowing access

CCaH Operators Conference

As part of its continuing effort to support this portion of the “at home” service field, CliftonLarsonAllen is pleased to sponsor the first ever CCaH Operators Conference, to be held in April 2013 in Plymouth Meeting, Pennsylvania. This will provide a forum for continued discussion among providers, the sharing of best practices and lessons learned, and discussion regarding the data elements that might be captured to better predict pricing and program performance moving forward. For more information about attending the conference, please call 609-760-2991.

to their campus. Other sponsors offer a range of options with sub-contracted, credentialed facilities, believing that consumers prefer the option to be closer to home for higher levels of care. Still other CCaH programs have opted to reimburse members for facility-based services no matter where they are provided in the continental United States.

FUTURE OPPORTUNITIES

The opportunities for continued innovation are intriguing. The *Patient Protection and Affordable Care Act* requires providers to consider new methods of payment for services, including bundled payment arrangements and other strategies to reduce health care costs. We believe CCaH programs can serve as a proven model for care management and coordination for these new payment arrangements.

In April 2009, the *New England Journal of Medicine* reported that over 19 percent of Medicare beneficiaries were readmitted within a 30-day period and 34 percent within a 90-day period. It was also reported that readmissions within 30 days alone accounted for more than \$15 billion in Medicare spending. At least two CCaH program managers have tracked the number of hospital readmissions among their members annually, and have found the numbers dramatically lower than expected.

Joan Krueger, director of Longwood at Home, the CCaH program affiliated with Presbyterian SeniorCare in Pittsburgh, Pennsylvania, shared her program’s experience.

“In 2011, 38 of our members were hospitalized for a total of 46 acute admissions. Only two members had re-admissions within 30 days. Both died of a terminal illness in less than four months after the first hospitalization. I believe our experience is attributable to the quality of our care coordination. The Longwood at Home care coordinators are actively involved in discharge planning, which includes referrals for Medicare-certified home care, private duty care, short-term skilled admissions, and other services. We get to know our members over time and can develop a more effective discharge plan based on our understanding of their support systems, level of independence prior to their hospitalization, family involvement, and home situation.”

According to Lynne Giacobbe, executive director of Kendal at Home in Westlake, Ohio, of the 140 hospitalizations of her members since 2004, only 11 percent were readmitted within a 30-day period, and less than 6 percent were readmitted within a six-month period. Like Longwood at Home, she also attributes this success to their care management model.

“It is the involvement of the care manager and the supportive services our members can access that enables us to impact readmission,” explained Giacobbe. “It is typically more than just calling if they need help. We most often are arranging for discharge and providing care in order to help the member recuperate fully and regain whatever level of independence is possible. So often older adults go home after a hospitalization with little or no support in place, ultimately resulting in readmission.”

About CliftonLarsonAllen

CliftonLarsonAllen's ThirdAge Solutions provides you with unique capabilities and a team of diverse professionals to guide you through today's complex aging-services issues. We are committed to serving the health care industry with more than 300 health care professionals operating in every region of the country. CliftonLarsonAllen is one of the nation's top 10 certified public accounting and consulting firms. The firm has a staff of more than 3,600 professionals, operating from more than 90 offices across the country. For more information about CliftonLarsonAllen, visit www.cliftonlarsonallen.com.

While this is anecdotal information, it underscores the potential value of the CCaH care coordination model. No doubt, this sharing of information is important for a nascent sub-industry. Sharing efforts began years ago and continue as many operators embrace both the opportunity presented by CCaH programs and the responsibility to learn from each other and improve this model.

CONCLUSION

Like most innovations, the concept of CCaH programs attracts replicators as well as skeptics. Both have a role in helping to shape, refine, and strengthen what has been a successful model of innovative care. We believe that the model is entering a new stage of maturity — not just in terms of overall experience and the utilization of health care related services, but as a platform leading to expanded roles for the care coordination expertise that has been developed, new product variations that are responsive to housing market trends and consumer preferences, and new approaches to engender a sense of community among members.

There are, of course, risks — just as there are for every service or program. Managing that risk is part of what strong leaders do every day.

About the Authors

Scott Townsley and Sarah Spellman have many years of experience working with senior living service providers. Prior to joining CliftonLarsonAllen, Spellman developed and operated one of the first CCaH programs in the country. She and Townsley have worked with most of the operating CCaH programs in the country, assisting these unique program providers with market research, program development and definition, actuarial assumption development, and operations development and improvement. Spellman has worked with many LeadingAge state affiliates in their efforts to write and foster regulations allowing for CCaH programs.

Sarah Spellman, Health Care Director
sarah.spellman@cliftonlarsonallen.com or 267-419-1645

Scott Townsley, Health Care Partner
scott.townsley@cliftonlarsonallen.com or 267-419-1647

The information contained herein is general in nature and is not intended, and should not be construed, as legal, accounting, investment or tax advice or opinion provided by CliftonLarsonAllen LLP (CliftonLarsonAllen) to the reader. The reader also is cautioned that this material may not be applicable to, or suitable for, the reader's specific circumstances or needs, and may require consideration of nontax and other tax factors if any action is to be contemplated. The reader should contact his or her CliftonLarsonAllen or other tax professional prior to taking any action based upon this information. CliftonLarsonAllen assumes no obligation to inform the reader of any changes in tax laws or other factors that could affect the information contained herein.