MARYLAND DEPARTMENT OF AGING

CONTINUING CARE

Continuing Care - What Is It?

Although the legal definition of "continuing care" is complex, in general, "continuing care" exists when all three of the following are present:

1) The consumer pays an entrance fee that is, at a minimum, three times the average monthly fee;
2) The provider furnishes or makes available shelter and health-related services to persons 60 years of age or older; and
3) The shelter and services are offered under a contract that lasts for a period of more than one year, usually for life.

As of January 1, 2019, there are 38 operating or approved continuing care retirement communities in Maryland, which are known as CCRCs. The Maryland Department of Aging ("Department") regulates specific matters related to the providers of continuing care. The continuing care laws of the State of Maryland can be found at Title 10, Subtitle 4, of the Human Services Article("HSA"), Annotated Code of Maryland ("Code"), and at Code of Maryland Regulations ("COMAR") 32.02.01.

The CCRC contract is known as a continuing care agreement, and a portion of its content is regulated by the continuing care laws. The continuing care agreement outlines the responsibilities of the provider and the resident with regard to continuing care. The agreements are legally binding contracts between the provider and that resident. These contracts also provide specific means for the enforcement of the terms of the contract between the provider and the resident.

Because only a portion of the content of continuing care agreements is prescribed by the continuing care laws, much of the content of continuing care agreements varies from community to community. As a result, the scope of the "continuing care" offered at different communities varies. For example, nursing care can range from full coverage in an on-site health center at no additional charge at some CCRCs, to simply priority admission to a nursing facility on a fee-for-service basis at other CCRCs.

Continuing Care - What are Some of the Consumer Benefits?

A CCRC may be an attractive housing and service option for a senior. Seniors who choose this living arrangement do so for many reasons, including emotional and physical security against unknown future health care needs.

Companionship in a community setting where social activities are available and opportunities are present for making new friends and establishing close relationships is another reason. Freedom from some of the demands of home maintenance may also be a consideration.

Often, the desire of seniors to be the planners of their remaining years without burdening their children or other loved ones is a consideration. Moving to a CCRC may prevent the need to make a major decision or move at a time of crisis, when it may be more difficult to determine the right choice.

Continuing Care - What are Some of the Consumer Considerations?

Entrance fees can be large sums of money that are paid in advance for services to be provided in the future. Therefore, the continuing financial health of the community may impact the provider's ability to provide the shelter, services and entrance fee refunds contracted for between the provider and the resident.

Many continuing care agreements with refundable entrance fees require the unit to be reoccupied, with payment of another entrance fee, before the refund is paid. Therefore, a delay in the re-occupancy of the unit may impact the ability to receive an entrance fee refund in a timely manner.

Typically, communities in Maryland increase monthly fees at least once a year. Provisions governing future fee increases appear in the continuing care agreement. Information on prior fee increases must appear in the continuing care disclosure statement. The Department of Aging does not have the regulatory authority to set or regulate fees. In addition to regular monthly fees, communities may also charge additional fees that are due on a monthly basis, such as for ancillary services.

Two weeks before a consumer executes a continuing care agreement, the provider is required to provide to the consumer a continuing care agreement, a continuing care disclosure statement, a copy of the written rules of the community, and a copy of the provider's latest certified financial statement. These documents can be used to help evaluate the financial position of a provider. If you are considering moving to a CCRC, the Department recommends that you consult with an attorney and/or financial advisor, who can help you to review the provider's continuing care agreement and disclosure statement.

If you are considering a new CCRC that is to be built, the continuing care laws require that certain deposits be maintained in an escrow account until after construction is completed.

Continuing Care - Who are the Providers?

Traditionally, CCRCs have been developed, owned and operated by non-profit organizations, such as church-sponsored or fraternal organizations. Churches or church related organizations have typically formed a non-profit corporation to serve as the provider, with which they may or may not have an ongoing legal relationship.

Although the great majority of continuing care providers in Maryland continue to be non-profit corporations, there are also a few for-profit businesses which serve as continuing

care providers in Maryland. Additionally, in a number of cases, for-profit businesses are under contract to non-profit providers to develop and/or manage particular CCRCs. The legal structure of a Maryland CCRC may include a cooperative housing corporation.

Continuing Care - Who Is the Regulator?

The Maryland Department of Aging is the agency charged with administering the continuing care laws. The authority given to the Department under the continuing care law is limited. The State of Maryland does not endorse or guarantee any continuing care community.

The Department reviews annually the audited financial statement, disclosure statement, and marketing of each CCRC. The Department does not have the authority to set fees or limit fee increases. Fees are determined by the provider or other entity providing the services and are affected by the marketplace. Increases in operating costs, especially the cost of health care, and low occupancy levels are two factors which can influence fee increases.

Approval of feasibility studies according to HSA §10-409(d) for new communities, or new units, means that the Department has determined that a market for the facility appears to exist and that a reasonable financial plan has been developed for.

Continuing Care - What is a Continuing Care Agreement?

The rights and responsibilities of residents and providers are stated in continuing care agreements. These agreements can be complex documents, and all consumers are advised by the Department to consult with an attorney and a suitable financial adviser before signing any documents.

A continuing care agreement is a legally binding contract between the provider and the subscriber (the resident), which typically remains in place until the subscriber leaves the community or is deceased. Continuing care agreements are reviewed by the Department of Aging for compliance with certain statutory and regulatory requirements.

Continuing care agreements are generally classified according to two basic criteria: (1) contractual entrance fee refund policies; and (2) the amount of assisted living and nursing home services provided without an increase in the monthly fee.

The law requires that the entrance fee be refunded if a continuing care agreement is terminated before the date of occupancy. A provider may only terminate a resident's agreement after the occupancy date if the provider has "just cause." If a provider does terminate an agreement for just cause, it is required to refund a pro-rated portion of the entrance fee to the resident.

If a resident terminates the agreement after the occupancy date, providers are not required by law to make any refund of the entrance fee. However, most continuing care agreements provide for some type of refund, at least for some period of time, when the resident terminates the agreement after occupancy. These kinds of refunds, which are not required by the continuing care law, but which providers agree to provide in their continuing

care agreements, are called contractual entrance fee refunds. Although particular agreements may contain variations, contractual entrance fee refunds are usually calculated on a percentage basis or declining balance basis.

Regardless of whether they use a percentage basis or declining basis contractual refund, most providers make the refund contingent on the receipt of a new entrance fee for the unit from a new resident.

Fees collected under continuing care agreements may not be used for purposes other than those set forth in the continuing care agreement. Some agreements limit the purposes for which such fees may be used to purposes related to the particular community. Other agreements allow fees to be used for broader purposes that extend beyond the community, such as furthering the provider's mission of providing services to the elderly. Effective October 1, 2012, each continuing care agreement is required to state whether the fees may only be used in the particular community or may be used outside the community.

Many continuing care agreements of nonprofit providers state essentially that it is the policy of the provider not to terminate a resident's agreement if the resident is unable to make payments due to unexpected financial adversity beyond the control of the resident, so long as the general financial well-being of the provider is not at risk

Continuing Care Agreements – How are Residents Charged for Assisted Living and Nursing Care?

The major health related services provided under a continuing care agreement are usually assisted living services and nursing home services. Although particular agreements may contain variations, how communities charge monthly fees for these services can generally be classified in one of three categories: (1) a fee-for-service agreement (sometimes called a Type C agreement), (2) an extensive agreement (sometimes called a Type A agreement), or (3) a modified agreement (sometimes called a Type B agreement).

First, in a fee-for-service agreement, a resident has to pay whatever the monthly fee for assisted living or nursing home care is when the resident needs those services. It will be higher than the monthly fee to stay in an independent living unit.

Second, under an extensive agreement model, although monthly fees are subject to increase from time to time on a community wide basis, an individual resident's monthly fee does not increase because the resident moves to the assisted living or the nursing home portion of the community.

Third, under a modified agreement, which is a hybrid of a fee-for-service and extensive agreement, acts as an extensive agreement, but only for a limited time. Under a modified agreement, a resident would typically be provided assisted living care or nursing care without an increase in the monthly fee for a limited number of days. The resident's monthly fee will likely increase then because fee-for-service assisted living rates and nursing home rates are usually higher than monthly fees for independent living.