



# Guide to Planning for Long-Term Care

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***Getting Your Business in Order* ebook series, Vol II**

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## Long-Term Care Will Cost More Than You Think

One of the most challenging aspects of planning for long-term care is the expense. For 15 years, Genworth Insurance Company has developed the Cost of Care Survey to help families plan for the costs of varying types of care across the U.S. Since 2004, the Cost of Care survey has become the foundation for long-term care planning.

According to The Genworth 2018 Cost of Care Study, the median cost of Long-Term Care in the the United States is as follows:

Adult Day Care \$18,720 per year/\$1560 per month

Assisted Living \$48,000 per year/\$4000 per month

Homemaker Services \$48,048 per year/\$4004 per month

In-Home Health Aide \$50,336 per year/\$ 4195 per month

Nursing Home (semi-private room) \$89,297 per year/\$7441 per month

Nursing Home (private room) \$100,375 per year/\$8365 per month

Alabama's median costs fare slightly better than the United States median, but are nonetheless staggering to consider:

Adult Day Care \$9,100 per year/\$758 per month (if available)

Assisted Living \$39,252 per year/\$3271 per month

Homemaker Services \$38,896 per year/\$3241 per month

Home-Health Aide \$38,896 per year/\$3241 per month

Nursing Home (semi-private room) \$75,347 per year/\$6279 per month

Nursing Home (private room) \$79,935 per year/\$6661 per month

The challenge faced by many caregivers, especially those working full-time, is accessing information about the range of prices in their individual communities. Prices and options can vary dramatically county to county, and there is no single state database of available prices. As an example, some counties have no adult day care services available at all, and the disparity between costs of assisted living can be dramatic, rendering families with no other option than to move a care recipient out of county and to other parts of the state. This is a stark reality that caregivers need to face before placements are needed. A tentative plan needs to be in the works here and now, not when a situation turns into a full-blown emergency.

Understanding that an appropriate long-term care plan is often pieced together with multiple resources is critical, and that is why learning about the various options now is essential homework for a caregiver. Long-term care begins at home for those who are able to make a plan of care to meet their needs while continuing to live in their own homes. The first step to accomplish this goal is to have a complete medical and social assessment to determine the services a person needs, and the second step is locating those services available through governmental programs at no additional expense as well as finding the money to pay for services that are not readily available through governmental programs.

## Home Care through Aging Services

Limited supportive services to help people stay in their homes are available through the Aging and Disability Resource Centers (ADRCs)/also known as Area Agencies on Aging (AAAs) throughout Alabama. There are 13 regional offices, and your local agency can be located at The Alabama Department of Senior Services. An array of services are available through Aging and Disability Resource Centers, but I will focus here on the most relevant to long-term care at home.

The Alabama Cares Program is a federally funded program offering limited support to caregivers and to grandparents who are raising their grandchild/children. Eligible persons include: adult family members providing care to individuals 60 or older or individuals with Alzheimer's disease and related disorders; non-parent relatives age 55 and older caring for children under 18; relatives (including parents) 55 and older caring for adults 18-59 with disabilities. Priority is given to caregivers in greatest economic and social need, and the maximum annual budget is a total of \$1,800. In extreme cases additional respite or supplemental assistance can be provided, but not in excess of \$3,000.

Caregivers are supported with information on resources, education and services including Case Management, Counseling, Respite, and Supplemental Services such as incontinent supplies and nutritional supplements.

Also available through the ADRCs, Home and Community Based Services (HCBS), also known as Medicaid Waiver Services, provide in-home services to older adults and persons with disabilities who are at risk of institutional care. Attention is given to client care, protecting the health and welfare of the client, and client free choices in providers and workers. Services available through this program include Case Management, Respite, Homemaker, Personal Care, Companion, Frozen Meals and Adult Day Health.

Services in the home through HCBS is the wave of the future. The only problem is that in Alabama a person has to have incredibly low income and resources to qualify for this service. A person with income greater than \$2313 could create a Medicaid Income Qualifying Trust to qualify for Medicaid to pay for institutional care, but that trust is not available to persons applying for care at home. There are also limits on resources that make this service available only to those with very modest savings, \$2000 in countable resources for a single person and \$27,284.00 for a couple (\$25,284.00 protected for spouse + \$2000 allowed for applicant).

## Home Care with Medicare

Medicare provides very limited long-term care assistance. It does not provide 24-hour care at home, meals delivered to the home, homemaker services, personal care or anything more than short term institutional long-term care in very limited circumstances. So it is important not to hang your long-term care expectations on Medicare.

Still Medicare does provide a number of services that, along with other services, can help a person remain at home. These services include Home Health Care, Hospice and durable medical equipment.

In order to qualify for Medicare Home Health Care Services a Medicare recipient must meet certain requirements. All of the following conditions must be met for Medicare to pay for Home Health Care Services:

1. A doctor must determine that the person needs medical care at home and must provide a plan of care;
2. The patient must need intermittent (part-time) skilled nursing care (other than only drawing blood), physical therapy, speech-language pathology, or continued occupational therapy services when the patient's condition is expected to improve in a reasonable time period;
3. The home health agency caring for you must be certified by Medicare as approved by the Medicare program to provide care; and
4. The patient must be doctor certified as homebound, or normally unable to leave home without help.

The "homebound" requirement does not mean that a patient must be unable to ever leave home in order to qualify for Medicare Home Health Services. It does mean that leaving home is not easy and takes considerable effort. A homebound person can go out for medical treatment or can leave home for short and infrequent non-medical reasons such as going to the hairdresser or church services. Further, a "homebound" person can leave home for adult day care and remain qualified for Medicare Home Health Care Services.

When the Medicare recipient meets the four threshold requirements listed above Medicare will pay for the following Home Health Care Services: Skilled Nursing Care, which includes nursing services that can only be performed safely by a licensed practical nurse or a registered nurse. These services can be provided on a part-time or intermittent basis.

Home Health Aide Services, which are services performed by an aide to support nursing services and includes personal care services such as bathing, toileting and dressing. While these services are performed by an aide who is not a licensed nurse, these services cannot be provided unless the patient is also getting skilled nursing services or other therapy.

Physical Therapy, Speech-language Therapy, and Occupational Therapy for unlimited times so long as a doctor indicates that these services are needed. Physical Therapy Services include exercise to strengthen the body or to restore movement that has been lost or teach a patient how to perform needed activities such as moving from a bed into a wheelchair. Speech-language Therapy are services to help a person regain or strengthen the ability to speak. Occupational Therapy is exercises to help the patient perform usual activities by himself or herself, such as helping a patient learn how to dress or perform personal care such as shaving. Occupational

Therapy can continue when ordered by the doctor even after skilled care is no longer needed.

There is no cost for Medicare Home Health Care services under Original Medicare, but the cost for durable medical equipment is 20 percent of the Medicare-approved amount. Hospice Services are a separate health care system provided to care recipients who are certified by their doctors to be terminally ill with a life expectancy of six months or less. The service is usually provided at the patient's home, and the patient or his legal representative must opt to receive hospice services rather than the regular Medicare services. Medicare services are normally provided to cure a patient of illness; hospice services are non-curative medical and support services designed to help the patient and his or her family move through the dying process. After the patient elects Hospice Services, he or she selects a Medicare certified hospice provider from a list of all providers in the area, and a care plan is developed. Hospice services may include home care and inpatient care as needed, and a variety of services not otherwise covered by Medicare. For instance, respite care is provided to allow family caregivers time to get away and recuperate. Hospice uses a team approach with the patient and family working with social workers, nurses, doctors, clergy and volunteers to collectively carry out the care plan to meet the needs of the care recipient. Of particular benefit for patients and families support, the hospice team can be contacted 24 hours per day, seven days per week. It is important that the patient and caregivers recognize that once Hospice Services are selected, the hospice provider directs the location of medical care, and the patient calls the hospice provider (e.g. the nurse in charge of direct care) even in emergencies for assistance in dealing with the medical issue.

The election to accept hospice services is an election for up to two 90-day periods followed by an unlimited number of 60-day periods, and the benefit periods may be used consecutively or at intervals. Regardless to how the benefit periods are used, the patient must be certified as terminally ill at the beginning of any benefit period.

Durable Medical Equipment (DME) is provided by Medicare Part B and includes reusable medical equipment such as hospital beds, walkers, wheelchairs, seat lifts, home oxygen equipment, etc. In order for Medicare to pay, the particular equipment needed must be prescribed as medically necessary by the care recipient's doctor, and the equipment must be provided by a Medicare certified supplier.

In-patient psychiatric care is covered by Medicare, though treatment facilities may be hard to find. There is a geriatric psychiatric unit at L. V. Stabler Memorial Hospital in Greenville (Butler County), Alabama, and can be reached at (334) 383-2247. The Acute Care for Elders (ACE) Unit at University of Alabama at Birmingham (UAB), which provides a multi-disciplinary approach to treat seniors in crisis.

## Veterans Benefits

The Veterans Administration offers benefits specifically for veterans and their dependents to help them cover the cost of attendant care. The pension benefits discussed here are either specifically tied to the veteran's or his dependent's low income or limitations in handling activities of daily life and need for help accomplishing those activities and IS NOT dependent upon service-related injuries for compensation.

Special Monthly Pensions are for veterans over age 65 who served for 90 days or more during active wartime who were honorably discharged. There are several types of benefits including New and Improved Pension (NIP), Housebound Benefits (HB) and Aid and Attendance (A&A).

To qualify for New and Improved Pension (NIP) the veteran or his spouse must have low income and resources..

To qualify for Housebound Benefits (HB) the veteran or surviving spouse must have low income and resources and need regular assistance, but does not have limitations as great as those who would qualify for Aid and Attendance.

To qualify for Aid and Attendance (A&A) the veteran or surviving spouse must have low income and resources and need the assistance of another person to perform daily tasks, such as eating, dressing, undressing, taking care of bodily needs, etc.

In October 2018 the VA began implementing new regulations to determine eligibility for these programs. Prior to that time the resource limit was \$80,000, but now the agency calculates net worth, which is one year of income plus all countable assets. Net worth must not exceed \$127,061 in 2019 to qualify. The home and two acres do not count even if the veteran is in a nursing home and not at home.

Calculating income requires a determination of unreimbursed medical expenses which are deducted from income. If, after deducting medical expenses, income drops below a certain level, the veteran can receive cash payments to bring his or her income back up to that limit known as the maximum annual pension rate (MAPR). Each benefit has a different MAPR. For instance, the MAPR in 2019 for a veteran with one dependent is \$2230.50 per month.

In the past veterans could transfer assets and qualify for benefits, but the new regulations establishes a three year look back to determine if assets were transferred that resulted in reducing the net worth below \$127,061. If so there is a penalty established by dividing the amount transferred above \$127,061 by \$2230 to determine the number of months of penalty.

To apply for benefits visit your county Veterans Officer. To locate that office and their hours use the map at the Alabama Department of Veterans Affairs web site at this address:  
<http://www.va.state.al.us>.

## Care At Home or in a Nursing Home With Long-term Care Insurance

Long-term care insurance was originally designed to protect purchasers from the catastrophic expense associated with long-term care in nursing homes. However, over time the public has clearly voiced a preference for home care over care in an institution. In response to that preference, long-term care insurance companies now offer a variety of in-home services to help individuals pay for services to assist a person with activities of daily living. In fact, most policies sold today are comprehensive policies that cover services in different long-term care settings including at home.

With the majority of policies sold today being comprehensive policies, they typically cover care and services in a variety of long-term care settings to include at home skilled nursing care, occupational, speech, physical and rehabilitation therapy, and personal care. Some policies also cover homemaker services, such as meal preparation or housekeeping as well; adult day health care center; hospital and respite; assisted living; and other residential care facilities and nursing homes.

Consumers should be aware of limitations on coverage, such as prior hospitalization requirements, and pre-existing condition exclusions. It is important to thoroughly understand what is being purchased, so a good deal of homework is involved in examining long-term care policies. Be sure that the services purchased are not services that are already covered by Medicare.

There are incentives in the form of resource protection offered by Medicaid to a person who does purchase long-term care insurance. For some policies issued after March 1, 2009, Medicaid offers incentives for those using long-term care insurance. When the long-term care insurance policy has paid at least the first three years of nursing home care and/or home health care services, Medicaid will not consider resources equal to the amount of benefits paid (dollar-for-dollar) by an Alabama Long-Term Care Insurance Partnership Policy (Partnership Policy) for long-term care services in determining Medicaid eligibility and in estate recovery. The amount to be excluded will be above and beyond the standard resource exclusion provided under the Medicaid State Plan. To qualify for this exclusion, the individual must be covered by a Partnership Policy that has been certified by the Alabama Department of Insurance as a policy that covers a person who was a resident of Alabama when coverage first became effective under the policy. Medicaid will provide reciprocity with respect to long-term care insurance policies covered under other state.

The main problem with long-term care insurance at this time is the increasing premiums with consumers across the country seeing sharp increases in premiums.

Another product on the market is whole life insurance from which the owner can draw to pay for long-term care. This "hybrid" policy will still pay your beneficiary if long-term care is not needed, and premiums are locked up-front.

## Independent Living

Often seniors will opt to downsize, sell their home and live independently in independent senior living facilities where recreation and community are focused values. Usually such facilities offer outstanding activities, and neighbors close in age, but no direct assistance other than the services previously described herein through the Area Agency on Aging and Medicare or privately purchased. There are multiple types of independent living communities, but these facilities share the common feature of limiting resident admissions to age 55 and older. The various types of independent living communities include subsidized senior housing, senior apartment complexes, retirement communities and continuing care retirement communities. Recognize that persons living in these types of communities still have ultimate control over their own lives and maintain independent home environments. Home based services can be provided in these communities just like in any home environment.

Subsidized senior housing is subsidized by the U.S. Department of Housing and Urban Development (HUD) and are available for low-income seniors. A person may move to subsidized senior housing to pay rent based on his or her income and to eliminate the high cost of living in a home they have had for many years that now is too hard to keep up. The senior would enjoy lower utilities, elimination of yard maintenance, homeowner insurance and property tax. The savings would free up funds needed to be able to pay for long-term care assistance with activities of daily life.

Senior apartment complexes can include community services as part of the rent charged. These services might be recreational programs, transportation and meals served in a communal dining room. While these services are not medical assistance, sometimes the community services are just the small amount of help a senior needs to continue to be able to live independently.

Retirement communities are usually considered single-family housing units of some description. The units might be condominiums, townhouses or single-family houses. While there is no defined requirement, retirement communities are generally places where individuals purchase a unit and pay additional monthly fees for additional services such as recreation, clubhouses, pools, etc.

Continuing Care Retirement Communities (CCRS's) are facilities that provide access to independent living, assisted living and skilled nursing facilities in one community. As a person ages and needs more care he or she can move to the next level. This can be a good arrangement for a married couple so that each can receive the care he or she needs while still living close together.

## Reverse Mortgages

Many people want to stay at home and pay for caregivers in the home. One way some people pay for that care is through the use of reverse mortgages by which home equity is converted to cash. A reverse mortgage is similar to a traditional equity line of credit, but with some big differences. Namely, the homeowner takes money against the home but does not have to repay the loan so long as he or she lives in the home, pays the property tax and insurance and keeps the property from deteriorating. The lender pays the homeowner in a lump-sum, monthly payment of a line of credit, and there are no restrictions on how the funds can be used. There are multiple types of reverse mortgages, but the type discussed here is a Home Equity Conversion Mortgage (HECM) insured by the federal government.

Persons age 62 and older can qualify for a HECM, and if the home is jointly owned, all owners must be 62 before the property is eligible to use a HECM. Unlike a traditional mortgage, when a homeowner applies for a HECM, he or she will not be required to provide an income or credit history to get the loan, and no monthly payments are due from the homeowner to the lender. Instead the lender makes payments at a given interest rate. Over time the loan amount increases, and when the last homeowner/borrower dies, sells the home or permanently moves out, the loan becomes due and payable. In that event the heirs of the homeowner can pay off the debt or the lender will sell the property to get back the money that was loaned.

The income from a HECM is non-taxable, but care needs to be taken that income not interfere with need based income such as 551. A person who qualifies for 551 can have a HECM, but only if the payment is spent during the month it is received. If money remains in the name of the 551 recipient the following month, it becomes a resource. If it exceeds \$2000 for an individual or \$3000 for a couple, 551 eligibility will be lost.

It is very important that a person fully understand how a reverse mortgage works before getting one. The HECM is offered by private lenders but are government insured. This means that if a person outlives his life expectancy or the value of property drops, the person will continue to receive the payments promised, and the proceeds recoverable by the lender is limited to the home alone. To be insured by the Federal Housing Administration (FHA), the borrower must pay, as part of the loan financed, an insurance premium along with an origination fee, servicing fees, closing costs, etc. In order to fully comprehend what expenses will be charged against the property and eventually taken by the lender, the federal government requires the HECM borrower to meet with a reverse mortgage counselor. The cost of that consult is rolled into the loan along with the other upfront fees.

## Assisted Living

Assisted Living Facilities are medically based care communities. From the outset, it is important to recognize that Medicare and Medicaid do not pay for assisted living facilities and there are some restrictions on who can live in these facilities. For many years assisted living facilities were not regulated in Alabama, but regulations were passed in 2001 following several well publicized cases of injury and death to persons living in Alabama assisted living facilities. The Alabama Department of Public Health is the agency responsible for regulating these facilities in Alabama.

Alabama regulations recognize two levels of care. They are the traditional Assisted Living Facilities (ALF) and Specialty Care Assisted Living Facilities (SCALF). Both levels offer assistance with activities of daily living, medications, community meals and help with bathing or dressing if needed, but the SCALF level of care has staff trained to work with residents who suffer from dementia, and they have architectural features to assure the safety and health of the residents who have diminished capacity. There are 306 assisted living facilities licensed in Alabama with 97 of those licensed for SCALF services, representing approximately 32 percent of Alabama's assisted living facilities licensed to provide SCALF services to some 2,720 residents.

Assisted Living Facilities (ALF's) must evaluate whether or not the facility can meet the needs of those applying for admission, and, generally, the ALF resident should not be "cognitively impaired" to where he or she cannot care for his or her own needs or direct others to do so when inability to care for his or her own needs arise from physical disability. Further, the ALF resident should not be a person with a level of dementia at risk for wandering since ALFs are not required to be locked facilities. Residents must be able to understand the unit dose medication system in use by the facility in order to live in an ALF.

Many people who would like to receive care in an ALF or SCALF cannot live there due to the cost of care not covered by Medicare or Medicaid. The cost of ALF and SCALF varies from facility to facility, and SCALF is more expensive than ALF, but as a general rule of thumb, ALF/SCALF care is half to 60 percent of the cost of nursing home care. The state median charge is approximately \$3271 per month for ALF. Considering that the maximum Social Security benefit rate in 2019 is \$2861, that cost places assisted living beyond the monthly income of many persons in Alabama.

## Nursing Home Care

It is never too early to begin exploring the options to pay for nursing home care because nursing home care frequently catches families by surprise. According to Medicaid, the average cost of nursing home care in Alabama in 2018 was about \$6200 per month, and the cost far exceeded that amount in urban areas of the state. It is not unusual to see care over \$7000 per month. At that rate a person will privately pay over \$84,000 per year for nursing home care.

Medicare covers only a limited amount of nursing home care and only if a person meets specific requirements. Medicare will pay for the first 20 days of care provided the patient has a three day prior hospitalization and is admitted to a nursing home within 30 days and requires skilled care. While the Medicare literature will indicate that Medicare pays for up to 100 days of nursing home care, the truth is that if the patient continues to have skilled care ordered by the doctor, on day 21 a co-payment of \$170.50 per day begins. That means that in a month even with Medicare paying, the patient will pay over \$5000 per month in co-payments. Under the best of circumstances Medicare will pay for only 20 full days of care and another 80 days if, and only if, skilled care continues to be ordered, and will pay for only about 1/3 of the cost of care while the patient pays \$170.50 per day. After 100 days Medicare pays nothing.

As you can see, qualifying for Medicaid to pay for nursing home care quickly becomes an important concern for those who will need nursing home care on a long-term basis. In order to qualify for Medicaid to pay for long-term care a person has to be medically sick enough and have income and resources low enough. The income limit in 2019 is \$2313, and if income exceeds \$2313 a Medicaid Qualifying Income Trust (MQIT) can resolve the problem of excess income. The resource limit is \$2000, but recognize that there are some types of property that can be excluded. For a married couple Medicaid considers what the couple jointly and individually owned on the "snapshot" date (when the person entered long-term care, which might be when he or she entered a hospital from which a placement was made to a nursing home). The home is protected for the spouse who will remain at home, and besides the home, he or she is allowed to keep the first \$25,284. If joint assets exceed \$50,000, the spouse who will remain at home can keep one-half up to a limit of \$126,420.

After Medicaid is awarded, a budget is prepared to determine the personal liability the resident is required to pay from his or her income. The resident can keep \$30 for his or her personal needs allowance, enough money to pay for unreimbursed insurance, and he or she is allowed to send home to the spouse at home enough of his or her income to bring the income of the spouse at home up to \$2058. The rest of the resident's income is paid to the nursing home as his or her personal liability, and Medicaid pays the difference in that amount and the nursing home charges.

If assets are given away Medicaid will deny coverage at the rate of one month for every \$6200 transferred within five years of application. This is why early financial planning for long-term care is so critical. There are multiple strategies to reduce countable assets, but some of those strategies, such as trusts, require a five year leeway before long-term care will be needed.

Spending down excess resources can include a number of methods, but many of these methods should happen prior to placement in long-term care (when the snapshot happens). This might include payment of debt to leave the spouse in a better financial situation or pre-payment of funeral expenses.

Another way to accomplish spend down without incurring a transfer penalty is to establish a special needs trust. Instead of spending all of the excess resources on the cost of nursing home care, the required spend-down funds can be placed into a pooled special needs trust, such as Alabama Family Trust, and the elderly person can begin receiving Medicaid benefits if otherwise eligible. Money in the trust can be used to provide things such as diapers, pajamas, clothes, a private room, or sitters in the nursing home. Meanwhile, Medicaid begins paying for the monthly room and board at the facility. There are different types of special needs trusts, but the type permitted in Alabama for persons over 65 are pooled trusts that require that money left in the trust at the death of the nursing home resident be used first to reimburse Medicaid for the cost of care for which the agency paid.

Another option for nursing home care is the Veterans Administration that has a federal and state program addressing health care needs of veterans. There are four VA nursing facilities in Alabama: Bill Nichols State Veterans Home in Alexander City; William F. Green State Veterans Home in Bay Minette; Floyd E. "Tut" Fann State Veterans Home in Huntsville; and Col. Robert L. Howard State Veterans Home in Pell City.

In the VA system State VA and Federal VA contributes toward the rate leaving the veteran responsible for the remainder. Actually this VA system is highly affordable nursing home care option after the state and federal government provide subsidies. In 2018 the out of pocket cost for care in the VA facilities in Alexander City, Bay Minette and Huntsville was \$355.02 per month, and the average wait for a bed was three to six months. The out of pocket cost for care in the Pell City facility was \$732 per month, and the wait for a bed was 12 - 18 months.

The VA is required to provide nursing home care to any veteran who needs nursing home care because of a service-connected disability, has a combined disability rating of 70 percent or more or has a disability rating of at least 60 percent and is deemed unemployable or has been rated permanently and totally disabled. Other veterans in need of nursing home care will be provided services if resources are available after the priority groups are served.

It is a violation of federal law to require the family of patients to sign up to be guarantor on the bill. To protect him or herself from personal liability, the individual should sign all documents, particularly the nursing home contract, as follows: Mary Smith by John James, power of attorney. The caregiver should never sign just his or her own name.