TAKACS MCGINNIS
ELDER CARE LAW

How We Plan For Long-Term Care of Our Clients

Planning for the care of our elder clients is not simply an exercise in which the elder law attorney and the family engage in transferring assets. At all times we must promote and maintain the good health, safety, well-being, and quality of life of our client-elder. To attain this, the highest goal of our planning, from time to time we may put strategies in place to "protect assets from the nursing home." Nonetheless, although asset protection may be a *function* of the Life Care Plan, it is never the *purpose* of the Plan.

Three Fundamental Planning Factors

Here is the way we explain what we do every day for our clients: we help them "find, get, and pay for good care." How we do this will be affected by three fundamental factors:

1. The Elder Care Continuum
2. Resources
3. Community and Policies

The Elder Care Continuum

Where is the elder located on the Elder Care Continuum?

We describe our planning as, basically, discovering our client-elder's place on the Elder Care Continuum and then figuring out what we need to do to find, get, and pay for good care for our client. That is not as easy as it sounds, but for an elder-centered law practice, it is the essence of what we do.

Think, then, about the Elder Care Continuum as a timeline on which the client-elder is moving along at the end of his life. The ideal for all of us is to "age in place." That invariably means the elder who lives in his own home, independently and successfully with no assistance needed, until he keels over dead in his living room or in his bed. Some people have the good fortune to depart life in this manner, but many do not. Instead, they may have Alzheimer's or Parkinson's disease, or suffered a disabling stroke, or become frail, or otherwise have found themselves moving along the Elder Care Continuum. They find that they need assistance with activities of daily living.

The term "activities of daily living," or ADLs, refers to the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring. When people are unable to perform these activities, they need help in order to cope, either from other human beings or mechanical devices or both. Although persons of all ages may have problems performing the ADLs, prevalence rates are much higher for the elderly than for the nonelderly. Within the elderly population, ADL prevalence rates rise steeply with advancing age and are especially high for persons aged 85 and over.

Instrumental activities of daily living (IADL) are activities related to independent

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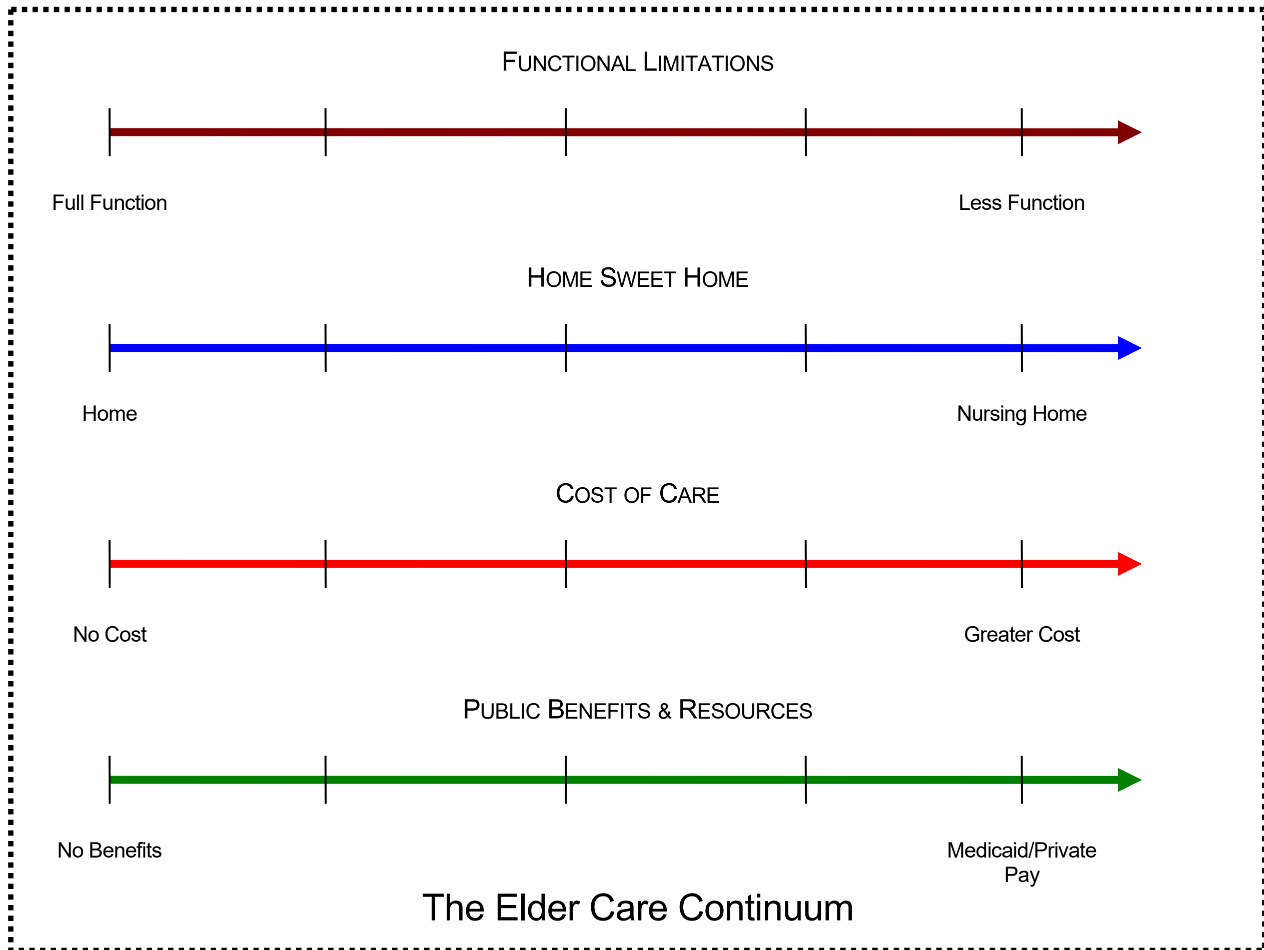
living and include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone.

Measurement of both ADLS and IADLs is critical because they have been found to be significant predictors of admission to a nursing home; use of paid home care; use of hospital services; living arrangements; use of physician services; insurance coverage; and mortality. Use of such services all describe the elder who is moving along the Elder Care Continuum, needing more assistance until the individual finds that he requires daily nursing home care.



The Elder Care Continuum

Resources

What resources are available to our client? In addition to public benefits that may be available to the client at reduced or no cost, access to long-term services and supports for the elder usually depends upon the client's own resources. Although long-term services and supports are available to persons with limited means, having money gives people more choices.

Marital Status and Family Supports

The most important resource for the elder is almost always a spouse and other family members. What is the marital status of our client-elder? Almost all of our "spousal cases," as we call them, present us with a husband and wife who are moving or have

moved along the Elder Care Continuum. They are seldom at the same place on the Continuum—a circumstance that certainly makes our planning for both of them challenging.

Individuals who need long-term services and supports often have family and friends that help them. Who are these caregivers and how many of them are there? In most instances, they are related to the individual: usually a spouse or a child. Sometimes the caregiver lives with the individual, sometimes caregiving consists of an occasional visit to the individual.

A study conducted for the National Alliance for Caregiving and AARP estimates there are 44.4 million caregivers who provide unpaid care to another adult. Almost six in 10 of these caregivers either work or have worked while providing care. And 62 percent have had to make some adjustments to their work life, from reporting late to work to giving up work entirely. Although a woman taking care of another woman is the most common of caregiving relationships, this is not just a woman's issue. Almost four in ten caregivers are men, and 60% of them are working full-time.

The study defined caregivers as people age 18 and older who help another person age 18 and older with at least one of the thirteen Activities of Daily Living or Instrumental Activities of Daily Living that caregivers commonly do on an unpaid basis. These activities range from helping another manage finances, shop for groceries, or do housework to helping another get in and out of beds or chairs, get dressed, get to and from the toilet, bathe or shower, or eat.

In our planning, we will identify our client's caregivers. They are vital to meeting the quality of life and care needs of our client and need support.

Other resources include:

Income

Most older persons have Social Security retirement income. Some have pension benefits, earned over a lifetime of employment with a single employer, that are a steady and seemingly assured stream of income for the rest of their lives.

A few of our older clients still have wages or self-employment income, to provide funds for investment and add routine and socialization to life. For our elderly clients who have chronic care needs, however, employment is usually not feasible.

Investments

Property and funds held for investment take many forms, including cash, bank accounts, CDs, IRAs and other retirement plans, life insurance, stocks, bonds, mutual funds, deferred annuities, investment real estate, and many other financial products. These assets often prove to be critical in attaining our goal to promote the good health, safety, and well-being of our clients. Surprisingly, many of our clients do not know what their net worth is and how their funds can be safely invested and tapped to improve their quality of life and quality of care.

Our client-elders typically view their monthly income stream from Social Security and pension as the foundation of their security. Appropriate investment counseling can help improve the client's financial situation by emphasizing safe investment appreciation and earnings. It thus becomes crucial for the elderly client and his or her care planning team (that's us, the Elder Care Law Practice) to consult with a qualified investment advisor who can be apprised by us of the client's immediate and projected long-term care needs.

The investment advisor must help analyze

the individual's risk tolerance, as well as an appropriate balance of income and equity growth, to devise a long-term care financial plan suitable for the client's circumstances.

The Home

Many persons are, understandably, emotionally attached to the homes they have worked hard to own and maintain. Many older clients underestimate the importance of their home for their future care and security. Their home is frequently their most valuable investment, and where they are likely to receive future long-term care services. The functional usefulness of the home should be judged in terms of the care, mobility, and transportation needs of our client and spouse, as well as the maintenance costs of the property.

With declining government support for long-term care services, it is becoming more common for individuals to use home equity to fund essential care. The financial value of the home may become available through a home equity loan, a reverse mortgage, or proceeds from the sale of the home. Many persons want to leave their home to their family through an immediate deed, life estate, or passing through their estate after death. Many financial, tax, Medicaid, and long-term case issues must be considered when transferring the home to family members, however. Many older persons will have to use the value in their home to fund adequate care for themselves and their spouse.

Our role as the Elder Law Attorney will be to help our clients build plans to constructively use home equity to access quality care for the balance of the their lives, and the lives of their spouses, partners, and other dependents.

Long-Term Care Insurance

The primary purpose of long-term care insurance is to provide access to quality long-term care services, not just to protect assets until the person can qualify for Medicaid. Long-term care insurance can complement a client's income, investments, and home equity as part of a strategy to fund appropriate long-term care services, regardless of the future availability of government assistance.

Medical and Health Insurance Coverage

Most elderly people have hospital, physician, and some skilled and rehabilitation care through Medicare with its companion Medicare supplement insurance known as Medigap. In order to access the limited Medicare coverage of skilled and rehabilitation nursing home coverage, a Medicare Advantage Plan or better Medicare supplemental insurance policy should be selected. Medicare Part D prescription drug coverage is a complex system that provides some subsidy for pharmaceutical purchases. If our client is a federal, state or municipal retiree with medical and health insurance coverage through a non-Medicare policy, we want to review what limited long-term care coverage is included in that policy.

Although some elders have retiree health care benefits, for most older Americans Medicare is the only medical insurance available. Our planning must take into consideration adequate health care coverage through Medicare, as well as proper utilization of the limited long-term care services available from Medicare.

Federal and State Long-Term Care Programs

For most middle and upper class older persons, Medicaid cannot be relied upon as the solution to financing home care, assisted living, or home health care.

There are persons with low income and

few assets. There also are persons in a better financial position who have not planned only to then suffer an abrupt illness or accident. For the immediate future, most such individuals and couples can be helped with a strategy to establish their Medicaid eligibility. But who knows how long that will be possible?

Many aspects of Medicaid—uncertainty, instability, restrictive eligibility and coverage, increased cost recovery even from future generations—are clear messages that our clients should avoid Medicaid if at all possible. In our planning, our clients will be able to rely on their own legal, financial, and resources much better than they can rely on federal or state programs.

With the ever-present possibility of federal and state legislative or regulatory changes, the future of Medicaid is too uncertain for rational financial planning. Congress, the courts, and waivers will continue to transfer major aspects of Medicaid eligibility, coverage and funding responsibility to the states. There will be increasing material variation among the various state Medicaid programs most commonly resulting in more restrictive Medicaid eligibility. Thus, in Tennessee's Medicaid program—TennCare—the program is administered by private managed-care organizations, with eligibility criteria weighted heavily to promote "cost savings."

State Medicaid agencies, under a federal mandate, are increasingly aggressive in collecting from the estates of anyone who received Medicaid after age 55. These "estate recovery" programs are in place in all 50 states and at a minimum require recovery for the probate estates of the deceased Medicaid recipient. Some states also attempt to collect from assets passing outside the probate estate. Medicaid is no longer free. At best it can be seen as a loan to be repaid from assets that outlive the Medicaid recipient.

Federal and state budget pressures on Medicaid will continue, and Medicaid will become a less and less desirable method of funding nursing home and other long-term services and supports.

Medicaid's political uncertainty, the program's instability, restrictive eligibility, reduced coverage, and increasing cost recovery are all clear messages that older persons and their families should avoid planning and applying for Medicaid if at all possible.

Community and Policies

Residential Care Facilities

Planning for long-term services and supports usually takes place within the context of identifying our client's housing and personal care options. We always ask these questions:

- Where is the elder currently living?
- Where will the elder live in the near future?
- Where will the elder live in the distant future?
- What suitable residential care facilities are available in the elder's community?
- What laws, rules, and policies limit or constrain access to these facilities?

Maybe our client needs more assistance at home; maybe he or she needs adult day services or other care in the community such as Meals on Wheels; or maybe our client needs to move out of the home and into a residential care facility. All housing needs are local; therefore, we must learn what home- and community-based services are available for our clients and the available housing options within the client's community.

Perhaps our most important responsibility

as attorney for the elder is to inform our client of these options, make recommendations, and advocate for quality of life and quality of care. Our client-elder's basic needs for food and shelter should be met in a safe and secure environment with minimal constraints on his day-to-day activities. We want that place to be our client's own home. Regrettably, for some persons who are elderly and disabled, often these needs can be met only outside the traditional home setting.

Most people seeking extended personal care outside the home want both an opportunity to live as normal and unconstrained a life as possible and a situation that will keep them functioning as well as they can. Concerns about quality of life and comfort ought to predominate over facilities' concerns about keeping the client "safe." Quality care is not just the absence of bad things happening in the care setting (such as falls, bedsores, or weight loss) that facilities organize themselves to prevent by restricting residents' liberty in the name of safety and security. Instead, good long-term care aims at least to slow the rate of decline in your client's physical, emotional, and social functioning. Viewed in this way, within a residential facility goals related to quality of life and quality of care are compatible rather than competitive.

When we speak of alternative housing for the elderly, that usually brings to mind a nursing home. Nursing homes provide care to persons who are chronically ill or recuperating from an illness and who need regular nursing care and other health services short of hospitalization. They usually provide rehabilitation programs, social activities, supervision, and basic room and food services. Nursing homes are state licensed and many are certified for Medicare and Medicaid reimbursement.

In many instances, though, a nursing home may not be the most appropriate solution to meet the needs of our client. A variety of alternatives have been developed that may be pieced together to fit the particular individual needs. These exist along a continuum of care levels, from shared living residences to continuing care retirement communities to nursing homes. These include:

- Shared living residences
- Foster care
- Boarding homes
- Homes for the aged
- Assisted-living residences
- Senior residential housing
- Residential health care facilities
- Continuing care retirement communities (CCRCs)
- Program of All Inclusive Care for the Elderly (PACE)

Nursing Homes

Some of our clients must be placed in a nursing home for long-term residential care. If so, as counsel and advocate for the client, we and the families of our elders must be familiar with the rights of the nursing home resident.

The most important tool in our arsenal for advocating the rights of the nursing home resident is the federal Nursing Home Reform Act (NHRA), enacted by Congress in 1987. The most important provision of this law says that the care provided to residents must be "in such a manner and in such an environment as will promote the maintenance or enhancement of the quality of life of each resident." This means that a plan of care must be developed for *each* nursing home resident; a cookie-cutter approach to nursing home care is not ac-

ceptable.

Steps in Tailoring a Plan of Care for Each Resident:

1. The NHRA requires that upon admission a “Minimum Data Set” (MDS) be developed to serve as a baseline for measuring progress under the resident’s care plan. The MDS includes, among other things, the resident’s medical history, social history, cognitive abilities, physical functioning, environmental needs, continence, mood and behavior patterns, oral and nutritional status, skin condition, and medication use.
2. Once the MDS is established, the facility must develop for the resident certain “Resident Assessment Protocols” (RAPs). These set forth specific guidelines and protocols for the staff to follow to address the needs identified by the MDS.
3. A written plan of care is then developed for each resident. It must be developed within seven days after completion of the assessment and reviewed “promptly after a significant change in the resident’s physical or mental condition” or at least annually. In the preparation of the care plan, the resident, the resident’s family, and the resident’s legal representative are entitled to participate and help formulate the guidelines for the plan.

The NHRA permits the nursing home resident’s legal representative to be involved in the development of the plan of care.

Supplemental Care

Although some of our work inevitably focuses on attaining Medicaid eligibility for a client in a nursing home, Medicaid provides a limited bundle of benefits. It finances care that must include certain required elements, including, among other things, nursing home care for residents in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the resident’s highest practicable physical, mental and psychosocial well-being, in accordance with the resident’s comprehensive assessment and plan of care.

There is, unfortunately, no compelling reason to assume the elder’s needs *will be* met in a nursing home. The shortcomings in nursing home care are well known. Studies indicate that nursing homes are challenged to provide consistent, high-quality care. Adequate staffing seems to be a system problem for these facilities.

In short, we cannot rely on a financing system that provides only minimal benefits in order to meet all of the needs of our clients. We must do more, if we can; and where resources are available we can do more, but only if we put in place a plan that provides supplemental care services for our Client-Elders.

First and foremost, therefore, our planning efforts are directed towards bettering the lives of our clients – who are the Elders and not the Elder’s children or other expectant heirs. Goals of the Plan are in this order of priority: (1) supporting and maintaining the good health, safety, well-being and quality of life of our Client-Elder; (2) assisting the Elder and his or her family with health care and long-term care decision making; and (3) preserving family wealth – first, for the benefit of our client, and second, for the benefit of our clients’ heirs.