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Long Term Care Options

This document outlines, in general terms, options available for extended or long term care along with some of the requirements to qualify for benefits to help offset the costs of such care. This is a general overview; each situation may vary based on the needs of the applicant, their income and other financial circumstances.

EXTENDED CARE OPTIONS in Pasco County

1. **Retirement Homes** Provide an apartment and basic living needs such as cleaning; meals, entertainment and transportation. These are private pay and any additional services such as medication management or personal care are added to the monthly costs. Depending on the facility; the size of the apartment; the number of people residing at the apartment, costs will range between $2500 and $5000 a month. There is no state program that helps to pay for this service.

2. **Assisted Living Facilities (ALFs**) Provide for increased personal care needs of the resident, such as bathing, dressing, and medication management. There are two types of ALFs; corporate run facilities, which provide apartment-type living with more privacy; and private facilities which are in neighborhoods, typically in converted homes. The accommodations in these types of facilities can be anything from a shared bedroom to a private bedroom and bath, but the living areas are common to all the residents. Depending on the facility and level of care, costs range from $2700 to $5000 per month. The state program that supplements the cost in this type of facility is called "Long Term Managed Care" (LTMC).” Because of the way the state of Florida funds the LTMC programs, it is very difficult to move someone directly from a home environment into an ALF with LTMC. There are long waiting lists. The qualification scenario to move someone into an ALF into a LTMC program more quickly is when the person needing the ALF has been in a nursing facility for 60-days (for rehab or other services), qualifies for Medicaid under the Institutional Care Program (ICP) they can then transition to an ALF with benefits from the LTMC program in an ALF.

3. **Nursing Facilities** which provide rehab services (normally covered through Medicare) and long-term care once Medicare benefits end. If the patient does not qualify for ALF services due to the level of required care, then they become a long-term patient in a nursing facility.

Once you determine what level of care is needed, and what programs are available to possibly offset the costs, then the applicant has the option of either private paying for the care from income and other resources or seeking eligibility for Medicaid/Long Term Managed Care benefits. If the assets and income are too high, then one of these scenarios could make them eligible:

REQUIREMENTS FOR MEDICAID ELIGIBILITY

Medicaid eligibility is determined by three criteria. The applicant needs to present evidence to the state that shows they meet these three criteria:

1. **Level of care**. This is determined by a form completed by the Nursing Home called a 3008 and by the CARES Unit.

2. **Income.** If an individual's gross income exceeds $2742.00 per month for 2023, then their application would be denied if they have not established and funded a Qualified Income Trust (QIT).

3. **Assets.** There are different asset requirements depending on the applicant's status (single; married; married with a disabled child). The current asset allowances and exemptions for 2023 are:

   Exempt property. If a property is exempt then the value is not relevant. The assets that fall into this category are:

   1. Homestead real property under $688,000.00
   2. Automobile
   3. IRAs that are paying the required minimum distribution (NOTE: The Income is not exempt and the amount must be added into to the applicant's other income to determine the amount of their "patient responsibility." (See discussion below)
   4. Irrevocable Pre-paid Burial plans
   5. Life Insurance with a face value under $2,500. If the face value exceeds $2,500 then you need to provide proof of the cash value and that amount is added into the amount of money an individual can maintain and still be eligible for benefits (see below).
   6. Rental Property (NOTE: The income generated by the property is not exempt and must be added into the applicant's other income to determine their "patient responsibility." (See discussion below).
   7. If there is a healthy spouse in the community, that spouse is entitled to keep $148,620.00 of other assets. If both spouses are receiving benefits then the amount is reduced to $3000.

   Once the exempt property is subtracted from the applicant's assets, the applicant is allowed to have the following:

   1. A bank account under $2,000 for a single person. If it is a married couple and both are receiving Medicaid benefits the amount is $3,000.
   2. A savings or checking account designate for burial services with less than $2,500.

   After the exempt assets are subtracted, if there is still too much money, then the option is either:

   A. Private pay until the assets are low enough

   B. Utilize one of the following strategies to move the money exceeds the limits out of the applicant's name so that their assets are low enough.

Please note, if you "gift assets" to anyone besides the spouse and apply for benefits within five (5) years of the gift, the application will be denied and the state will impose a penalty period in which the applicant will be ineligible for benefits.

STRATEGIES FOR ALLOCATING ASSETS TO MEET ELIGIBILITY STANDARDS:

Personal Service Contract

This is a contractual relationship in which the patient agrees to pay an amount of money for services to a "Provider" who will agree to provide care to the patient. The payment is determined by a mathematical computation based on the patient's age and life expectancy; an assumption of the number of hours that the provider will be paid for and an hourly rate. The advantage of this method is it is a quick transfer of a large amount of money. The disadvantages are that the money needs to be out of the patient's control, so when the patient makes the payment, they are relying on the "Provider" to continue to care for them after they have control of the money. Also, this would be considered income to the provider and they should report and pay tax on it in the year in which it is received.

Pooled Trust

A set amount of money is deposited with an independent money manager (Trustee) in a Pooled Trust. While the parties are alive, they may request the Trustee make payments from the trust for their special needs not otherwise covered by Medicaid. These needs can be clothing; private duty care; the differential for the private room rate not otherwise covered by Medicaid; taxes and maintenance on the homestead. The disadvantage is that when the patient passes away, the state has a lien on any remaining balance of money to the extent the state paid out benefits. If there was money after the lien, it would be remitted back to the patient's estate and beneficiaries.

Reverse Half Loaf

Reverse Half Loaf is a nickname for a complicated procedure. Under this strategy, the patient would gift an amount of money. The gift would create a penalty period. During the penalty period, the patient would have to private pay for the cost of care. Because of the way the penalty is computed, they would not have to pay all of the penalty period and they would end up saving approximately one half to 2/3rds of the gifted amount. Example - a $30,000 gift would create a penalty period of 3.36 months. If their monthly private amount was $8,944 then by the time you paid the cost of care, plus the penalty period, the time frame for ineligibility would be reduced from 3.36 months to 1.5 months and you would pay about $10,000 for care and save about $20,000 of the gifted amount.

Rental Property

If the patient used a portion of their money to acquire rental property, the value of the rental property is exempt. The income that the property generates is not exempt and would have to be included when computing their "patient responsibility," but the value of the asset is exempt. An educated assumption of the costs of taxes, insurance, and maintenance would be deducted to determine the net amount of income for the "patient responsibility." The disadvantage of this strategy is that finding and purchasing a piece of rental property and then leasing the property

takes time and during that time period the patient would be ineligible and need to private pay the costs of care. In addition to the time factor, if there was an unexpected expense or a loss of income, then there would have to be money set aside to cover those expenses. If these issues are a concern, there is a company that takes the payment to purchase a fractional interest in real estate and incurs acquisition and management of the property to make the time delay and unexpected costs less.

Spousal Refusal

If one of the spouses did not need care, they are the Community Spouse. They could take the assets out of the institutionalized spouse's name and then file an application stating they "refused" to use their assets to pay for the cost of care of the institutionalized spouse. The limitation is that when the patient uses spousal refusal, all of the institutionalized spouse's income needs to go to the facility to pay their cost of care or "patient responsibility" and the community spouse does not get to request a portion of their spouse's income. In addition, the community spouse needs to update their estate planning documents so that if they predeceased the institutionalized spouse, that the assets would not go back to the institutionalized spouse and make them ineligible for Medicaid.

NOTE: If spousal refusal is a possibility but the spouse still needs a portion of the income, there is a strategy which would require a separate court proceeding to request Spousal Support Unconnected with a Dissolution of Marriage. This would be a separate court case and an additional fee to the retainer for the Medicaid planning is required.

PATIENT RESPONSIBILITY

Once the applicant's assets are deemed to be eligible, the patient will be assessed a "patient responsibility" which is based on their monthly income. The "patient responsibility" is defined as the amount of their monthly income the patient owes directly to the facility to offset their cost of care. The patient may only keep $130.00 per month from their income. If there is a spouse in the community, the community spouse may apply for a spousal resource allowance to be paid directly to them. The amount of the resource allowance is determined by a formula assigned by Medicaid.

VETERANS BENEFITS

If the applicant is a qualified veteran, there is a program through the Veterans Administration (VA) that does provide financial assistance to people in their home or in a retirement home. This program may pay for a portion of the costs, but it is a long process to access those benefits. Also, the rules governing eligibility with the VA sometimes conflict with the rules that govern eligibility for Medicaid. If you decide to pursue VA benefits you need to make sure that you don't inadvertently create problems accessing Medicaid benefits while doing VA planning. Call us, we can help.

SUMMARY

This document covers a lot of points and provides a general overview of the options for care that are available in the State of Florida, along with options to access benefits to help offset the cost of care. What is best for your family will depend on the needs of the applicant, their income and other financial circumstances. If you wish to discuss the options further, please call 727-584-2110 to schedule an appointment with one of our attorneys. To ensure a productive discussion, please bring:

- An accurate view of the applicant's income
- A list of assets, what type of asset and how each asset is titled.
- If there have been transfers in excess of $1000 within last 5 years