LENDER LAW AND LIFE CARE PLANNING

Leaving the Skilled Nursing Facility: A Guide for Families

If a patient is unable to return home, where do they go? How will they pay for their care? Who will make the decisions?

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Increasingly, hospitals are places for only acute care, such as major surgery, intensive care or comprehensive testing and immediate treatment for a serious illness. Once the crisis has passed, the patient is often transferred to a Skilled Nursing Facility (SNF). These facilities are able to administer medications and provide intensive therapy to get patients back on their feet.

When the medical personnel at the SNF have determined that a patient no longer needs that level of treatment or is not responding further, the SNF will notify the patient and family that the patient will be discharged.

What should you do if you know that you are not able to take care of your husband when he gets home, or if you’re afraid that your mother can’t take care of herself? What should you be thinking about, and what decisions do you need to make?

1. Is the patient really ready to leave?

The SNF is required to give families at least three days’ notice, in writing, before a patient is discharged. If you believe the patient would benefit from staying longer, you can file an appeal with Medicare asking that they continue to pay for SNF care. The discharge form should include the phone number you can call to file this appeal. If it does not, ask the SNF Discharge Planner for this information.

If you agree that the patient will no longer require that level of care but you need time to make arrangements, ask the Discharge Planner if the patient can stay for a few days on a private pay basis.

2. Can I get some help to take care of the patient at home?

There are many “non-medical” home care agencies that can provide aides to assist with bathing, dressing and transferring. They can also help with cooking, light housekeeping and transportation. Aides can be provided for a few hours or for 24-hour care.

Some agencies will bill a long-term care insurance company directly, and others accept payments from the Arizona Long Term Care System (ALTCS, which is the Medicaid program in Arizona) if the patient is otherwise eligible. Look under “home care agencies” on the internet or in the Yellow Pages, or the Discharge Planner may have some recommendations.

Some non-profit agencies can also provide a few hours of care, respite for family caregivers, or meal preparation for little or no cost. Examples in the Phoenix area include Duet (www.duetaz.org, 602-274-5022) or the Area Agency on Aging (www.aaaphx.org, 602-264-2255).

There are also agencies that provide home medical care, such as administering intravenous medications, and physical, occupational or respiratory therapy. You can find these under “medical home care.” The Discharge Planner or home care agency may also have some recommendations. If your doctor has ordered medical care at home, he may select the provider or make a recommendation. To the extent that this care is consistent with your doctor’s order, it is likely that the cost would be covered by Medicare Part A or B.

3. If the patient can’t go home, where can she go?

There is a wide variety of residential care facilities in Arizona. These are some of the terms you will hear:

- **Independent Living** options are usually apartments or patio homes for individuals above a certain age. The living units are designed with aging adults in mind, so they are usually one-story with wide doorways and nothing that would impede a walker.
or wheelchair. Some meals in a common area may be included, or at least available, and there are usually a variety of planned social activities. Many adults are able to stay in Independent Living facilities for many years with the assistance of home care agencies.

- **Retirement Communities** are restricted to residents over a certain age (e.g., 62), and they usually provide a lot of social activities. Sun City, Sun Lakes and Leisure World are examples of Retirement Communities in Maricopa County. The living units are usually barrier-free, and they may have some of the other types of facilities listed here on their property, but the basic Retirement Communities do not provide any services or assistance to residents who need a little extra help.

- **Assisted Living** is for adults who need help with everyday tasks. They may need help with dressing, bathing, eating or using the bathroom, but they don’t need full-time nursing care. The residents may live in small studio apartments or a single room, with or without a roommate, and the facilities provide meal service and social activities similar to (and sometimes shared by) Independent Living facilities. Some Assisted Living facilities are part of Retirement Communities. Others are near Skilled Nursing facilities, so a person can move easily if needs change.

- **Memory Care** facilities are specifically licensed to care for individuals with dementia. As with Assisted Living facilities, they can be free-standing, or they can be part of Retirement Communities, which would enable a resident to transition from one level of care to another, or allow spouses to live on the same campus.

- **Care Homes** are private residences licensed by the State of Arizona to provide Assisted Living and/or Memory Care level of care to a small number of residents (usually fewer than 10) in a home setting. Care Homes are often less expensive than institutional facilities.

- **Continuing Care Residential Communities** (CCRCs) are communities that include Independent Living, Assisted Living, Memory Care, and Skilled Nursing facilities on the same campus. Once someone has paid the fee and moved into the Independent Living area, she can progress to the other sections if and when needed for little or no further cost.

### 4. What does this care cost?

There is a range of costs for every type of care that can be chosen. Home care agencies charge an hourly rate, and the cost of Care Homes or other residential facilities can range from approximately $3,000 to $8,000 per month or more, depending on the amenities and level of care provided.

### 5. How will we pay for this?

Most families pay for Long Term Care from their income and savings. If you purchased private Long Term Care insurance, or it was provided by your employer, it can help offset some of the cost.

Some public benefits may be available to help. For example, veterans who served during wartime or their surviving spouses may be eligible for a pension benefit, including an additional benefit if they are homebound or require regular aid and attendance. Also, the Arizona Long Term Care System (ALTCS) will cover the cost of long-term care for individuals who meet strict medical and financial criteria.

### 6. What about Medicare?

Medicare does not cover the cost of non-acute or “custodial care,” such as non-medical home care, independent or Assisted Living, or even residence in a memory-care unit for people suffering from dementia due to a stroke, Alzheimer’s or other cause.

Medicare will cover up to 100 days in a Skilled Nursing facility if the patient had been admitted to a hospital for at least three days within 30 days of admission to the SNF. If at least 60 days have passed since the patient was discharged from an SNF, and the patient is admitted back to the hospital for at least three days and is then discharged to the SNF, the “clock” starts over again. There is no limit to the number of times Medicare will cover 100 days of skilled nursing, provided it is preceded by at least 60 days outside an institution, and at least three days of hospitalization.

Medicare will pay 100% of the cost of the SNF during a period that is covered. After that, Medicare Part A covers 80% of the cost. If the patient has a supplemental insurance policy, that policy will cover all or part of the remaining 20%; if the patient does not have a supplemental insurance policy, the patient is personally responsible for that co-pay. Once Medicare will no longer cover Skilled Nursing care, either because it is determined not to be medically necessary or the 100 days has run out, a supplemental policy will not cover it either. However, some supplemental policies will cover up to one year, as long as the care meets the Medicare definition of “medically necessary.”
Medicare Part A will also cover the cost of medical care provided at home, if it is ordered by a physician and follows a period of hospitalization. Medicare is currently in the process of transitioning the payment of all home care to Part B.

Medicare Part B pays for most (but not all) medical home care if it was included in the discharge orders from the SNF or prescribed by a physician. There is no cap on the amount or duration of care that they will pay for, as long as a doctor continues to order it.

7. **Who decides where the person should go?**

Ideally, the patient will be able to express his preference about where he wants to go and the type of care with which he is most comfortable. If this is not possible due to illness, the next best thing is for the patient to have signed *advance directives* when he was competent to make decisions. Advance directives authorize someone to act on a person’s behalf when illness prevents her from making an informed decision or she is not able to communicate the decisions she has made.

There are several types of advance directives:

- **A general power of attorney** appoints an agent to make financial decisions on behalf of the incapacitated adult, such as paying bills and managing assets.

- **A health care power of attorney** appoints an agent to make healthcare decisions on behalf of an incapacitated adult, such as where she should get care, what kind of treatment is acceptable, and when the decision should be made to withhold further treatment. In many cases, a *living will* goes hand-in-hand with a health care power of attorney. This is the document in which an individual expresses her desires about health care decisions.

- **A mental health power of attorney** is either a separate document or a part of the healthcare power of attorney that is signed separately, appointing an agent to make the decision to admit the patient into a Level One Mental Health facility. In Arizona, a secure memory care unit is considered such a facility. Arizona is one of only a handful of states that requires this specific authority.

If there are no advance directives, the individual may be able to sign a *health care proxy* to name someone who can make decisions about a particular period of hospitalization or care. For financial decisions, an individual may have given a child signature authority on their bank account, or their assets may be held in trust and managed by a trustee.

As Arizona is a community property state, an individual’s spouse generally has equal authority to make decisions regarding financial matters. In extreme cases, when no agent has been appointed and the individual is physically or mentally incapacitated, a guardian and/or conservator may need to be appointed by the Probate Court to make decisions for the individual.

8. **Who can help with all of these decisions?**

Placement Services can help you identify a residential facility that meets both your care needs and your budget and can coordinate the admission process.

Geriatric Care Managers can assess the patient’s needs, make recommendations for care providers, interface with the patient’s doctors, and make sure that all services are coordinated.

An attorney who specializes in wills and trusts or elder law can help with advance directives, guardianships and conservatorships and benefits planning. Forms for health care powers of attorney and living wills are available on the Arizona Attorney General’s website (www.azag.gov).

**Life Care Planning**

Elder law attorney **Marsha Goodman** and elder care coordinator **Tracy Swanson**, RN provide many of these services in a single, integrated “Life Care Plan.”

As a team of legal and social services professionals, Marsha and Tracy work with you and your family to develop a plan of action to handle your loved one’s legal, financial, health care, housing and long-term care needs now and in the future, including assistance qualifying and applying for public benefits if they should become necessary.

Once the plan is in place, Tracy monitors the care and serves as the family’s advocate, in conjunction with Marsha’s expertise with any legal challenges that may arise.