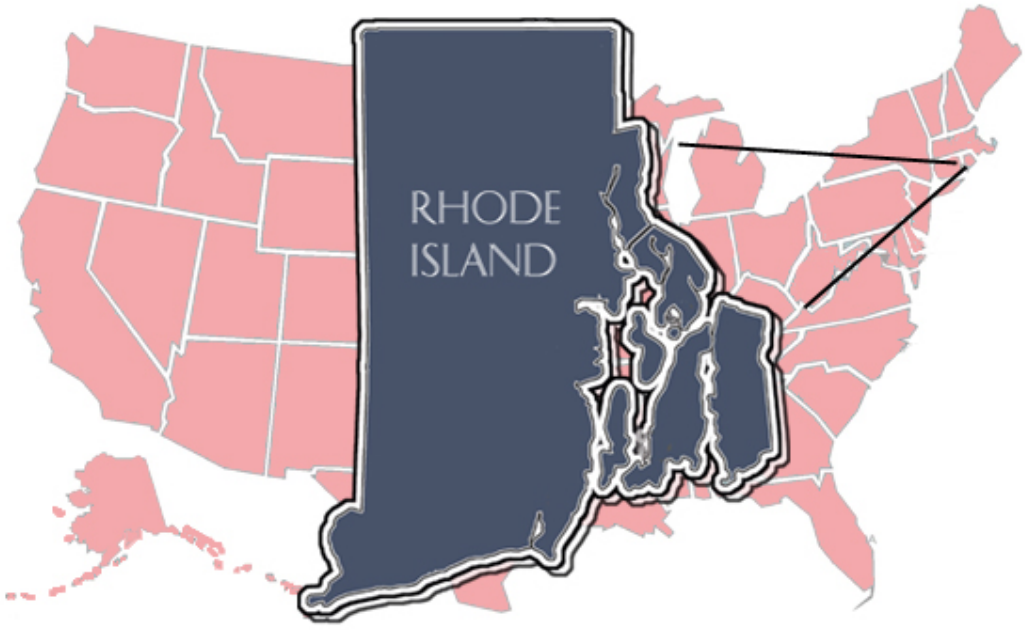
Doing LTC RIght



CENTER FOR LONG-TERM CARE REFORM

OCEAN STATE
POLICY RESEARCH INSTITUTE

Doing LTC RIght

presented by the

Ocean State Policy Research Institute
"Free Market Answers in Rhode Island"

In cooperation with the

Center for Long-Term Care Reform
“Dedicated to ensuring quality long-term care for all Americans”

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Table of Contents

Doing LTC RIght

Executive Summary:

- Caring for the frail and infirm elderly is difficult and expensive. Today, America's long-term care delivery and financing system is a mess.
- Rhode Island has been a case in point.
- Most people receive long-term care in nursing homes funded inadequately by a public welfare program called Medicaid.
- Ideally, most people would receive long-term care in their homes and communities, but arcane federal Medicaid rules have precluded that result.
- Rhode Island Medicaid sought and received a "global Medicaid waiver" enabling it to manage long-term care more effectively in exchange for a cap on federal funding.
- The state is implementing a new system of clinical eligibility that makes more home care and less institutional care available to Medicaid recipients.
- But, demographic pressures (the Age Wave) and financial pressures (the recession and government deficits) presage huge future problems for long-term care.
- This report examines whether Rhode Island's ingenious global waiver strategy can achieve its goal of rebalancing long-term care without breaking the bank.
- The report explains how long-term care in the USA and Rhode Island came to be dominated by publicly financed institutional care.
- It describes how Medicaid became the dominant payer for long-term care not only for the poor, but for most of the middle class, and many of the affluent.
- The report argues that financing quality long-term care for all Rhode Islanders will require more private financing to supplement dwindling public funds.
- It explains why potential private long-term care financing alternatives, such as home equity conversion and private insurance, have languished to date.
- Finally, this report recommends a course of action whereby Rhode Island Medicaid can ensure clinical success and financial viability under the global waiver.
- "Doing LTC RIght" offers a model for long-term care reform that could reduce institutional bias, increase access and quality of long-term care, and save money.
- If Rhode Island does LTC right, the rest of the country may follow its example.

Introduction

This report is the product of a collaboration between the Ocean State Policy Research Institute of Providence, Rhode Island (OSPRI, www.oceanstatepolicy.org) and the Center for Long-Term Care Reform of Seattle, Washington (CLTCR, www.centerltc.com).

Earlier work products from this project include a report titled "The Age Wave, the Ocean State and Long-Term Care," versions of which are available on OSPRI's and CLTCR's websites. We also published an op-ed in the *Providence Journal* titled "R.I. Medicaid Has Sprung a Leak" on September 17, 2009.

Information on how this project was funded is in the "Appendix: Recognition of Donors." All financial support for the project was private. No public funds were used.

The subject of long-term care delivery and financing, especially as it involves Medicaid eligibility, is complicated and often esoteric. We have attempted to keep this report as simple and straightforward as possible. But much of what you read herein will contradict widely held beliefs about the subject.

Therefore, we recommend that you review the report in a special way. First, suspend your disbelief temporarily. Read only the text. It's intended to make the argument as concisely and compellingly as possible. Disregard the footnotes at first reading. Ask yourself, if this is true, do the conclusions and recommendations make sense?

Next, re-read the report critically. When you see something in the text that contradicts conventional wisdom, read the footnote and decide which to believe--conventional wisdom or the facts as stated and verified.

I want to make one thing crystal clear. All of the problems discussed in this report spring from federal law and regulations. Rhode Island Medicaid staff have no choice but to implement and enforce those rules as written and interpreted. They have done a superb job in that regard.

What is new and exciting is that Rhode Island's global Medicaid waiver opens opportunities to manage scarce Medicaid resources in ways that make more sense and provide better results for the state's neediest citizens. We hope this report provides insights and suggestions that will facilitate the achievement of that objective.

Overview

Long-term care (LTC) delivery and financing in the USA is seriously dysfunctional.[1] We have a welfare-financed, nursing-home-based LTC system in the wealthiest country in the world where no one wants to go to a nursing home.[2]

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[1] For a summary of the problems and the solutions, on which most experts agree, see Stephen A. Moses, "LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle," Center for Long-Term Care Financing, Seattle, Washington, September 1, 1998, pps. 3-4, http://www.centerltc.com/pubs/CLTCFReport.pdf.

[2] For a primer on America's LTC financing system, including detailed profiles of ten states' Medicaid programs (five of the most successful and five of the least successful), see Stephen A. Moses, "The Realist's Guide to Medicaid and Long-Term Care," Center for Long-Term Care Financing, Seattle, Washington, September 7, 2004, http://www.centerltc.com/realistsguide.pdf.

Yet most of the American public is asleep about the enormous risk and cost of long-term care. Few plan to save, invest or insure so they can pay privately for care if and when it's needed.[3]

Most who need expensive long-term care slip sooner or later onto Medicaid, a means-tested public assistance program.[4]

Long-term care in Rhode Island is no exception and key demographic and other data on RI do not bode well for the future.

For example, compared to other states, Rhode Island ranks

- 43rd in total population but 5th in percent of population over 85 years of age;
- 3rd in elderly with Alzheimer's Disease;
- 6th in nursing home recipients age 65 plus;
- 2nd in nursing home expenditures per Medicaid recipient;
- 39th in home and community-based services as a percent of long-term care spending;
- 44th in the ratio of family caregiving value to Medicaid cost; and
- 42nd in median household income for people age 65 plus.[5]

Medicaid is the dominant LTC payer in the Ocean State.[6] The cost is enormous and growing.[7] Long-term care for the elderly accounts for a disproportionate share of Rhode Island's Medicaid expenditures.[8]

Like the U.S. as a whole, only more so, Rhode Island's Medicaid-financed LTC is dominated by nursing facilities, which most people would rather avoid.[9]

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[3] For an explanation of why most Americans fail to prepare to pay privately for long-term care, see Stephen A. Moses, "The Myth of Unaffordability: How Most Americans Should, Could, and Would Buy Private Long-Term Care Insurance," Center for Long-Term Care Financing, Seattle, Washington, September 1, 1999, http://www.centerltc.com/pubs/Myth.pdf.

[4] For an explanation of how and why most people end up in nursing homes on Medicaid when they need expensive long-term care, see Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care," Cato Institute, Policy Analysis No. 549, September 1, 2005, Washington, DC, http://www.cato.org/pubs/pas/pa549.pdf.

[5] Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, pps. 272-277, http://www.aarp.org/research/ppi/ltc/Other/articles/across_the_states_2009__profiles_of_long-term_care_and_independent_living.html, cited December 9, 2009.

[6] "The Rhode Island Medicaid program is the chief source of funding for long-term care for individuals with limited-means . . .. Whether the state's Medicaid program is an affordable and appropriate platform for addressing the needs of the uninsured is thus an important and, as yet, unresolved question." (State of Rhode Island, Executive Office of Health and Human Services, "The Future of Medicaid," October 2007, p. 1, http://www.eohhs.ri.gov/reports/documents/RIFutureofMedicaidFinal%20Report-10-07.pdf, cited December 9, 2009.)

[7] "In Rhode Island, there is an emerging consensus that the Medicaid program as it is now configured can no longer be sustained in the current fiscal environment. At issue is the gap between state revenues and Medicaid operating costs." ("Future of Medicaid," *op. cit.*, p. 6)

[8] The elderly are ten percent of RI Medicaid recipients (17,478 out of 176,647), but account for 25 percent of costs ($431 million out of $1,745 million). (State of Rhode Island, Executive Office of Health and Human Services, "Rhode Island Annual Medicaid Expenditure Report - State Fiscal Year 2008," undated, p. 19, http://www.ohhs.ri.gov/documents/documents09/RI_Medicaid_Expend2008_final.pdf.) Furthermore: "The elderly account for $431 million in total 2008 Medicaid health care spending, and the highest average cost per member per month (pmpm) of $2,056. Costs for this population are dominated by nursing homes, which account for $290 million or roughly two-thirds (67%) of spending on the elderly population." (*Ibid.*, p. iv)

[9] "Since the program's inception in the mid 1960s, federal Medicaid guidelines have always had what is referred to as an 'institutional-bias' - that is, both eligibility for and access to covered services are more readily available to individuals requiring services in nursing facilities, hospitals and other institutional settings." ("Future of Medicaid," *op. cit.*, p. 6)

Likewise, access to Medicaid-financed home and community-based care, which most people prefer, is very limited--again more limited than in most of the rest of the country.[10]

Furthermore, like most Americans, few Rhode Islanders prepare in advance to pay privately for LTC through savings, investments or insurance.[11]

Public officials in RI recognized these problems and took creative, arguably radical, measures to address them.

The state now has a unique "global Medicaid waiver"[12] under which Rhode Island agreed to a five-year cap on otherwise unlimited federal Medicaid matching funds in exchange for extra flexibility under federal laws and regulations to operate the program more effectively.[13]

Rhode Island's global waiver is a big gamble, but likely a good one if implemented in full recognition of the issues discussed in the remainder of this report.

So far, state officials have used their new flexibility and authority under the global waiver, as it bears on long-term care for the elderly, primarily to change clinical eligibility rules as a means to reduce nursing-home use and increase access to home and community-based alternatives by Medicaid recipients.

Based on our interviews with the state Medicaid Director,[14] the Director of Policy, Executive Office of Health and Human Services,[15] and the Administrator, Office of Institutional and

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[10] As the global Medicaid waiver begins, Rhode Island's Medicaid long-term care funding goes mostly to nursing homes (approximately 90 percent) and less to home and community-based care (10 percent).

[11] Long-term care insurance agents interviewed for this project told us that sales are weak, flat or down. Reverse mortgage specialists told us their product is rarely used to fund long-term care. (Based on interviews with representatives of both professions on July 10, 2009 and follow-up emails.)

[12] The United States Department of Health and Human Services Centers for Medicare and Medicaid Services approved Rhode Island's "Global Consumer Choice Section 1115 demonstration" for a period of five years on January 16, 2009. The approval letter, signed by Acting Administrator Kerry Weems and fully documenting the waiver's conditions, is available at http://www.eohhs.ri.gov/medicaid/pdf/GlobalWaiverFinal1-09.pdf.

[13] Governor Carcieri described the global waiver's role in Medicaid reform thus: "For Medicaid, the reform will convert the service delivery model from provider based to client-centered in programs in the Departments of Human Services, Children, Youth and Families, and Mental Health Retardation and Hospitals. The program will emphasize personal responsibility, home and community-based solutions, innovative delivery of services. Global Consumer Choice Compact Section 1115 Demonstration (i.e. the 'Global Waiver') will provide flexibility to the State to achieve these goals." (Donald L. Carcieri, "State of Rhode Island and Providence Plantations Executive Summary Fiscal Year 2010," March 9, 2009, http://www.budget.ri.gov/Documents/CurrentFY/ExecutiveSummary/1_Complete%20FY%202010%20Executive%20Summary.pdf.)

[14] Interview with State Medicaid Director Elena Nicolella on October 28, 2009 and by phone on December 11, 2009. Rhode Island Medicaid has used the global waiver to do three things for LTC services they could not have done under federal law and regulations without the waiver. First, they've changed clinical criteria to allow people who do not meet the threshold to qualify for nursing home care to receive Medicaid in the home or community. Second, they've collapsed all the former 1915c Medicaid home and community-based waivers into a single system. Third, they are claiming federal matching funds for certain services that were previously financed with state-only funds. The global waiver allows the state much greater flexibility to operate its program more efficiently and effectively while rebalancing away from Medicaid's traditional institutional bias. So far, according to Ms. Nicolella, they are on schedule with implementation of the global waiver (a) having developed the procedures and organizations to implement nursing home transition and diversion and (b) having established a new nursing home acuity-based payment methodology. Next steps include continuing the actual onsite diversion work and developing the capacity for providing delivery of home and community-based services by setting rates that are sufficient to ensure availability of services and affordable for the program.

Community-Based Services and Supports,[16] as well as other state officials responsible for implementation of the global waiver, we believe Rhode Island is on course to achieve its goal to rebalance the Medicaid LTC program toward less institutional care and more home care.

Such success is bound to please current and future Medicaid recipients.

- But will it save money?
- How will nursing homes adapt to losing their lower acuity (i.e. more profitable) residents?
- Can the alternative care venues encouraged by the waiver, such as adult day care, home care and assisted living, satisfy the extra demand for their services at rates Medicaid can afford to pay?
- Will Medicaid's funding more of the services people prefer (home care) and less of the services they'd rather avoid (nursing home care) further discourage private LTC planning and financing and thereby leave more and more of the cost of long-term care with public programs?
- What can policy makers do to ensure that the answers to these questions will be beneficial for all concerned--care givers, care receivers, and care funders--as the massive baby-boomer Age Wave crests and crashes?

These are the key issues we will address in this report.

But first, before we can answer these specific questions, we must confront, explain and resolve a puzzle that affects long-term care delivery and financing both in Rhode Island and the USA.

Why Does Medicaid Pay for Most Long-Term Care?

If long-term care is such a high risk of catastrophic financial loss as often asserted,[17] why is it that most people who need LTC end up on Medicaid, a means-tested public welfare program,[18] but statistics show little evidence the public has to spend down savings before qualifying for government assistance?[19]

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[15] Interview with Ann Martino, Director of Policy, Executive Office of Health and Human Services, on December 3, 2009.

[16] Interview with Ellen Mauro, Administrator, Office of Institutional and Community-Based Services and Supports, on December 3, 2009.

[17] Several long-term care insurance companies conduct surveys that document the high cost of LTC services including "The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs" (http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf), "The Genworth Financial 2009 Cost of Care Survey" (http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.8024.File.dat/cost_of_care.pdf) and Prudential's "Long-Term Care Cost Study", http://www.prudential.com/media/managed/LTCCostStudy.pdf.

[18] "The social safety net has a significant impact on the State's budget and the economy. In the enacted fiscal year 2010 budget, for instance, grants and benefits account for 46 percent of State and federal spending in Rhode Island. . . . In Rhode Island, based on Census data, of the growth in spending between 1992 and 2006, 90 percent of social service spending went to support Medicaid. . . . In fiscal year 2006, approximately 30 percent of Medicaid beneficiaries (elderly, adults with disabilities, and children with special health care needs) accounted for 79 percent of total spending in Rhode Island." (Rhode Island Public Expenditure Council (RIPEC) and United Way of Rhode Island, "Social Safety Net Study for Rhode Island - Data Analysis Summary and Conceptual Framework," June 2009, p. ii, http://www.ripec.com/matriarch/d.asp?PageID=66&PageName2=pdfsdoc&p=&PageName=Safety+Net+Final+Full+Report+8+04.pdf, cited December 9, 2009).

[19] America spent $138.4 billion on nursing home care in 2008. Of that, Medicaid paid 40.6 percent; Medicare, 18.6 percent; other public funds, 3.0 percent; private health insurance, 7.4 percent; and other private funds, 3.7 percent. Only 26.7 percent of nursing home funding was paid "out of pocket" and, as we'll explain below, half of that was spend-through of Social Security income of people already on Medicaid. (Source: U.S. Department of Health and

Americans face a 69 percent probability of needing some long-term care and a 20 percent probability of needing five years or more.[20]

LTC in Rhode Island is very expensive whether provided in the home (home health aide, $25 per hour; homemaker, $21 per hour) or in adult day care ($63 per day), assisted living ($3,157 per month) or a nursing home ($233 semi-private room per day, $254 private room per day).[21]

Yet the vast majority of expensive long-term care throughout the USA--including Rhode Island--is funded by third parties such as Medicaid, Medicare, and private insurance or by spend-through of Social Security income or other private income by people already on Medicaid.[22]

One can account for 85 percent to 90 percent of the entire cost of expensive long-term care in the United States and in Rhode Island without touching any of anyone's personal savings.[23]

The conventional wisdom that people all across the country are being forced into impoverishment by the high cost of long-term care is demonstrably false and has been so for decades.[24]

But, what if it's true that most people can ignore the risk of long-term care, avoid the responsibility to save, invest or insure for that risk, wait to see if they ever need expensive LTC and, if they do, get someone else to pay?

If that is true, wouldn't it make sense that most Americans and most Rhode Islanders don't worry about long-term care until it's too late to prepare responsibly and therefore end up on the public program that pays for most long-term care?

If it is true that most people can safely ignore LTC risk and cost, wouldn't making even more desirable services available through the publicly financed plan invite financial peril for the state and federal government, compounding costs at a time when new revenues are curtailed?

Human Services, Centers for Medicare and Medicaid Services, National Health Expenditures Data, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, Table 9, cited January 8, 2010.) The situation with home health care financing is very similar to nursing home financing. America spent $64.7 billion on home health care in 2008. Medicare (41.1 percent) and Medicaid (34.6 percent) paid 75.7 percent of this total and private insurance paid 9.0 percent. Only 10.2 percent of home health care costs were paid out of pocket. The remainder came from several small public and private financing sources. Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, National Health Expenditures Data, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf, Tables 4 and 11, cited January 8, 2010.

[20] "While an estimated 31% of people currently turning 65 will not need any LTC before they die, 20% will need care for more than five years." (Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?," *Inquiry*, Vol. 42, Winter 2005/2006, p. 342.)

[21] Figures cited are average private-pay rates for Rhode Island as reported in MetLife Mature Market Institute, "The 2009 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," October 2009, http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-market-survey-nursing-home-assisted-living.pdf, cited December 9, 2009.

[22] See Micah Hartman, *et al.*, "Health Spending Growth at a Historic Low in 2008," *Health Affairs*, Vol. 29, No. 1, pps. 147-155, http://content.healthaffairs.org/cgi/content/full/29/1/147 and Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care," Cato Institute, Policy Analysis No. 549, September 1, 2005, Washington, DC, http://www.cato.org/pubs/pas/pa549.pdf.

[23] See Stephen A. Moses, "LTC Bullet: So What if the Government Pays for Most Long-Term Care?, 2008 Data Update," Center for Long-Term Care Reform, Seattle, Washington, January 13, 2010, http://www.centerltc.com/bullets/latest/855.htm.

[24] Stephen A. Moses, "The Fallacy of Impoverishment, *The Gerontologist*, Vol. 30, No. 1, February 1990, pps. 21-25.

But how can it be true that people qualify for public funding of their expensive long-term care without first spending themselves into financial ruin?

That is in fact how Medicaid long-term care financial eligibility actually works despite the common view that getting government to pay for LTC requires "spend down" into "impoverishment."

How Medicaid LTC Eligibility Actually Works

Most of what one reads in the media, trade journals, or even in peer-reviewed research articles, says that Medicaid long-term care eligibility requires poverty-level income and asset spend down into penury.[25]

The whole truth is more complicated. On the income side, Rhode Island has a medically-needy income eligibility system.[26] That means the state deducts the cost of private nursing home care and other insurance and medical expenses from a Medicaid applicant's income before asking if any remaining income meets the poverty-level standard.[27]

Consequently, successful applicants for Medicaid long-term care do not have to be low income.[28] They only need to have a cash flow problem after they have paid all their LTC and medical expenses.[29]

Rhode Island's Medicaid eligibility policy chief told us he has only seen eligibility denied to two applicants based on excess income during his decades of experience with the program. And those were "oddball cases."[30]

But what about assets? Don't Medicaid applicants have to spend down their personal savings privately for their own care until they get down to a draconian limit of $4,000?

No again.

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[25] For example: "Elderly adults eligible for Medicaid must be 65 years of age and meet the state's income and assets tests. Income eligibility is generally limited to 100 percent of the FPL ($817 per month for an individual in FY 2006) for individuals who meet the age criteria, though there are exceptions. In terms of resources or assets, individuals with income at or below the federal poverty level may have up to $4,000 in countable assets." ("Future of Medicaid," *op. cit.*, p. 16, footnote omitted)

[26] "As is the case for adults with disabilities, the program also extends eligibility to elders with income higher than the poverty level, who have considerable medical expenses and qualify as 'medically needy.'" ("Future of Medicaid," *op. cit.*, p. 16).

[27] Interviews with Deborah Castellano, Chief Case Work Supervisor on October 28, 2009 and with Medicaid LTC eligibility workers (Social Case Workers) on October 28, 2009

[28] "Income is not a problem with the global waiver. For all intents and purposes, [recipients] can get HCBS [home and community-based services] regardless of income. We use spousal impoverishment rules even though they're not going to a nursing home." (Interview with Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on July 7, 2009.)

[29] In some cases, higher income people qualify for Medicaid so that the nursing home or home care provider receives the low Medicaid reimbursement rate but Medicaid has to make no vender payment because the recipient's income covers the entire Medicaid-level payment. Thus, a potential private-pay patient at market rates becomes a Medicaid patient at rates below cost without Medicaid's incurring any expense. (Interviews with Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on July 7, 2009 and Deborah Castellano, Chief Case Work Supervisor, on October 28, 2009.)

[30] Interview with Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on July 7, 2009.

Federal Medicaid rules, with which Rhode Island is required to abide, do not require that assets be spent down specifically *for long-term care*.

"Take a world cruise" or "throw a big party" some experts advise. As long as you don't give assets away for less than fair market value to qualify for Medicaid, no "transfer of assets" eligibility penalty applies. Applicants and recipients may purchase any amount of exempt assets in order to reduce their resources to the Medicaid eligibility limits.

Furthermore, allowable exempt assets are virtually unlimited. In addition to the $4,000 in cash that recipients are allowed to retain, they may also keep the following without affecting their Medicaid eligibility[31]:

- A home and all contiguous property up to $500,000 in equity.[32]
- One business including the capital and cash flow of unlimited value.[33]
- Retirement funds such as Individual Retirement Accounts (IRAs).[34]
- One automobile of unlimited value if used for the benefit of the Medicaid recipient, which is assumed.[35]
- Unlimited prepaid burial plans for the Medicaid recipient and immediate family members.[36]
- Unlimited term life insurance.[37]

Medicaid exempts many other assets but those are the major ones, except for household goods discussed below. Again, these exemptions are mandatory under federal law and regulations.

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[31] Citations to Federal regulations for the following asset exemptions and others may also be found in Stephen A. Moses, "Aging America's Achilles' Heel: Medicaid Long-Term Care," Cato Institute, Policy Analysis No. 549, September 1, 2005, Washington, DC, http://www.cato.org/pubs/pas/pa549.pdf.

[32] Federal Medicaid LTC eligibility rules exempted unlimited home equity, including the value of all property contiguous to the home, until the Deficit Reduction Act of 2005, signed into law by President Bush on February 8, 2006, capped the home equity exemption at $500,000 or $750,000 depending on state legislative option. Rhode Island opted for the lower cap. New York, California, Massachusetts and Idaho opted for the higher cap.

[33] "Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990." Social Security Administration, *Program Operations Manual System (POMS)*, http://policy.ssa.gov/poms.nsf/lnx/0501130501.

[34] "A recipient could have $500,000 in an IRA and it's not counted." (Interview with Deborah Castellano, Chief Case Work Supervisor, Department of Human Services on October 28, 2009.) Mandatory periodic payments from retirement accounts are counted as income but rarely cause ineligibility.
Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01120.210: Retirement Funds," https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120210!opendocument.

[35] "One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. ASSUMPTION: Assume the automobile is used for transportation, absent evidence to the contrary. Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.200: Automobiles and Other Vehicles Used for Transportation," http://policy.ssa.gov/poms.nsf/lnx/0501130200. Emphasis in original.

[36] "A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value." Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.400: Burial Spaces," http://policy.ssa.gov/poms.nsf/lnx/0501130400.

[37] "[T]he FV [face value] of the following are not taken into account: burial insurance policies; and term insurance policies that do not generate a CSV [cash surrender value]." (Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.300: Life Insurance," http://policy.ssa.gov/poms.nsf/lnx/0501130300.) Why would a 90-year-old buy a million dollar term life policy when the premium would almost equal the benefit? Instantaneous self-impoverishment and the term insurance benefit passes to the beneficiary at death thus avoiding Medicaid's "mandatory" estate recovery requirement.

Do these federal rules cause Rhode Island Medicaid to expend more state resources for long-term care than would otherwise be true? Undoubtedly. Consider, for example, the home equity, prepaid burials, and household goods exemptions.

Home Equity

Over 80 percent of seniors own their homes and over 70 percent of these own their homes free and clear.[38] State staff told us 1,140 LTC recipients or only about 12.7 percent of the caseload still own homes.[39] Thus, most of the elderly's home equity disappears before they start receiving Medicaid LTC benefits.[40]

How much equity is lost and what happens to it?[41] Some possibilities include transfers outside the five-year transfer-of-assets penalty window,[42] sale of the home with re-purchase of an interest in an adult child's home,[43] and life estates with reserved special powers.[44]

It behooves the state to find out what's happening to home equity that could otherwise relieve the financial pressure on Rhode Island Medicaid to fund long-term care.

Even after most of the equity has disappeared, Rhode Island Medicaid still exempts millions of dollars of home equity for LTC recipients. It's hard to say exactly how much because average home values by state are difficult to pin down.[45]

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[38] "The vast majority of Americans age 65 and older in 2004 (82 percent) are homeowners (Callis and Cavanaugh 2004). Over half the net worth of seniors is currently illiquid in their homes and other real estate (Orzechowski and Sepielli 2003).[p. 1]
"Based on the Health and Retirement Study, in 2000 there were 27.5 million elder households with at least one resident age 62 or older. A high proportion (21.1 million) of these households (78 percent) were homeowners (Figure 3.2). About 74 percent owned their homes free and clear of any mortgages. In aggregate, elder households have accumulated over $2 trillion in home equity. [p. 26]
(Barbara R. Stucki, "Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action," The National Council on the Aging, January 2005, http://www.ncoa.org/Downloads/ReverseMortgageReportPublications.pdf.)

[39] Email from Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on November 20, 2009.

[40] Eligibility workers told us in an interview on October 28, 2009 that "Houses are frequently transferred more than five years in advance but not assets. A ten-year transfer of assets look-back could save more. Houses are different than money. They give away money in the 11th hour. With the house, we have public records to trace."

[41] The house often disappears between the time of original eligibility and later redetermination. The "golden apple is always the house," said Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services during an interview on December 1, 2009 with eligibility technicians who conduct the redeterminations.

[42] Assets transferred for less than fair market value for the purpose of qualifying for Medicaid within five years of applying for Medicaid create an eligibility penalty in months equal to the amount of assets so transferred divided by the average cost of a nursing home in the state. Assets transferred earlier than five years incur no penalty no matter how great the amount.

[43] This is a Medicaid planning technique state workers are seeing more and more. The Medicaid applicant sells a home, uses the proceeds to purchase an interest in someone else's home (usually an adult child's residence) and then claims that property interest as exempt because of an intent to return to a home. Medicaid exempts homes to which recipients "intend to return." State staff have objected unsuccessfully so far on the grounds that no one can "return" to a home in which they've never lived in the first place. They said most of these cases have come from a single law firm and they expressed hope that others would not start using the loophole. "If this is allowed to continue, there will be nothing to recover [from estates]."

[44] The elderly Medicaid applicant transfers the remainder interest in a home to an heir (usually an adult child) while retaining a life estate, i.e. the right to live in the home until death, including the right to mortgage, sell or convey an interest in the property, i.e. "special powers." State staff insist this should be a transfer of assets but that the Centers for Medicare and Medicaid Services (CMS) have allowed it.

[45] The median net worth of elderly households in the United States is $130,500 of which $109,950 is home equity. (U.S. Census Bureau, Alfred O. Gottschalck, Current Population Reports, "Net Worth and the Assets of Households:

But if the 1140 homes currently exempted have only an average value of $75,000, the total value exempted would be $85,500,000.

But isn't that money recaptured later by Medicaid estate recovery? Much of it could be but little of it is recovered as we will explain below in the section on estate recoveries.

Prepaid Burials

Prepaid burials are another huge exemption that diverts public funds from purchasing long-term care services to financing the funeral industry.

State eligibility workers estimated that 75 percent to 80 percent of all elderly Medicaid LTC recipients purchase prepaid burials averaging $8,000 to $12,000 in value. A quarter more have purchased prepaid spousal burials as well. The highest exempt prepaid burial the workers had seen was $18,000.[46]

By comparison, the Cremation Society of Rhode Island reports that the average cost of a conventional funeral is only $5,000 and the "State's assistance for cremation" of an indigent is $850.[47]

Even applying the lower range of these estimates to the roughly 9,000 elderly Medicaid LTC recipients in Rhode Island, yields $67,500,000 being diverted at any given time from long-term care financing to burial costs at public expense.[48]

When new Medicaid applicants have not already purchased prepaid burials, workers routinely encourage them to do so.[49] This advice qualifies the applicant for public assistance faster, increases Medicaid's costs, and reduces private-pay revenue to long-term care providers.

It is controversial, but still a valid public policy question to ask whether state and federal Medicaid funds are more appropriately expended to provide quality LTC services to needy seniors or to indemnify heirs for their parents' final costs by subsidizing expensive funerals.

2002 Household Economic Studies," P70-115, Issued April 2008, Table 4. Median Net Worth and Median Net Worth Excluding Home Equity of Households by Age of Householder and Monthly Household Income Quintile: 2000 and 2002, p. 10, http://www.census.gov/prod/2008pubs/p70-115.pdf, cited December 9, 2009.)
Home ownership in Rhode Island is somewhat less common (60.0 percent) than in the country as a whole (66.2 percent) but the median value is higher in RI ($133,000) than in the USA ($119,600). (U.S. Census, "State and County QuickFacts," Rhode Island, http://quickfacts.census.gov/qfd/states/44000.html, cited December 10, 2009.)
According to the American Housing Survey for 2007 (http://www.census.gov/prod/2008pubs/h150-07.pdf), the median value of an elderly-owner-occupied home in the United States was $168,654. According to the Historical Census of Housing Tables Home Values (http://www.census.gov/hhes/www/housing/census/historic/values.html), the median value of a home in Rhode Island as of 2000 was 11.2 percent higher than the national average.

[46] Seven Medicaid "social workers" and supervisors, with an average of 13 years each in the job, provided these estimates to us in a meeting on October 28, 2009.

[47] Cremation Society of Rhode Island's website at http://www.csori.com/faqs.htm, cited December 15, 2009.

[48] Calculation: 9,000 elderly Medicaid LTC recipients times 75 percent who have prepaid burials times $8,000 average per person plus 25 percent for spousal prepaid burials equals $67,500,000. At the higher estimates provided by staff, the numbers would be: 9,000 times 80 percent times $12,000 plus 25 percent or $108,000,000.

[49] The practice of routinely informing Medicaid LTC applicants of their right to purchase personal and spousal prepaid burials for the purpose of exempting additional assets from spend down requirements was affirmed in meetings with Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on July 7, 2009; with Deborah Castellano, Chief Case Work Supervisor, Department of Human Services on October 28, 2009; and with seven social case workers and supervisors on October 28, 2009.

Personal Property

Household goods are officially excluded under federal regulations from Medicaid's asset eligibility limits regardless of value. Rhode Island does not routinely inquire about personal property even though it is a "countable resource" if held for "its value or as an investment."[50]

Medicaid LTC eligibility workers said "There is no limit on home furnishings nor do we have personnel to see what applicants and recipients have. We have "no clue of what is in the homes."[51]

Medicaid Planning

Beyond the already very generous eligibility rules imposed by federal law and regulations on Rhode Island Medicaid, many attorneys in the state specialize in highly technical methods to impoverish more prosperous elders artificially for the purpose of qualifying them to receive Medicaid-financed long-term care.[52]

The National Academy of Elder Law Attorneys (NAELA), the Medicaid planners' professional association, lists 28 members in Rhode Island on its website at http://www.naela.org/MemberDirectory/default.aspx.[53]

A typical internet ad for Medicaid planning in Rhode Island reads: "We help clients understand their rights and avoid common mistakes as they plan a transition to a nursing home or an assisted living facility, *enabling them becoming* [*sic*] *eligible for Medicaid while preserving their hard-earned assets*."[54]

Only one of the Rhode Island Medicaid planning attorneys we contacted agreed to speak with us on the record. She said she has a legal responsibility to her clients to get them everything they're entitled to under the law. So she makes use of all the many legal tools available to facilitate Medicaid eligibility. "I don't think the general public understands the system and what is or isn't available to them as they age."[55]

Medicaid planners use techniques such as Medicaid friendly annuities,[56] promissory notes,[57] "reverse half-a-loaf" strategies,[58] irrevocable income-only trusts,[59] purchase of exempt assets,[60]

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[50] Social Security Administration, *Program Operations Manual System (POMS)*, "SI 01130.430: Household Goods, Personal Effects and Other Personal Property," http://policy.ssa.gov/poms.nsf/lnx/0501130430.

[51] Interview with seven Medicaid "social workers" and supervisors, with an average of 13 years each in the job, provided these estimate to us in a meeting on October 28, 2009.

[52] An internet search (Google) for "Rhode Island Medicaid Planning" yielded 94,500 hits on December 15, 2009.

[53] Cited December 15, 2009.

[54] Source: http://www.mignanelli.com/Practice-Areas/Elder-Law-Medicaid-Planning-and-Guardianships.shtml, cited December 15, 2009, emphasis added.

[55] Discussion with Jill E. Sugarman, Esq., of McLaughlin & Quinn, LLC, Attorneys at Law, on December 3, 2009. Email follow up, December 17, 2009.

[56] A typical case of this kind involves putting a couple's excess assets into an annuity for the community spouse. It's not a penalizable transfer because fair market value is received in the form of a cash stream. Workers we interviewed on October 28, 2009 estimated five percent of elderly LTC cases use annuities averaging $100,000 to $150,000 to qualify. One spousal annuity case involved $750,000 resulting in immediate Medicaid nursing home eligibility in which Medicaid pays only $200 per month because of the high income stream from the annuity. The nursing home gets the low Medicaid reimbursement even though the client could easily have paid the full private-pay rate indefinitely. Tom Conlon, Administrator of Long-Term Care and Adult Services reviews all cases involving annuities including 83 such cases received between January 1, 2009 and October 27, 2009.

life estates with "special powers," and purchase of an interest in an adult child's home to hasten eligibility for relatively affluent clients.[61]

From tens to hundreds of thousands of dollars or more may be involved in each of these Medicaid planning gambits. A rule of thumb for the cost of Medicaid planning is that attorneys' fees to qualify for Medicaid will be roughly equal to the cost of one month in a nursing home at the private pay rate, or around $7,777.

State Medicaid eligibility policy staff and workers informed us that such techniques are already common and are increasing in number and in the amounts of money sheltered or divested to gain access to Medicaid-funded LTC.

One LTC provider we interviewed complained that he'd admitted an ostensibly private-pay patient to his nursing home who initially reported $930,000 in net worth. A few months later, this individual qualified for Medicaid retroactively using a spousal annuity to shelter the excess assets.

Adding insult to injury, the nursing home owner had to refund $32,000 in private payments he'd received for this newly destitute resident when Medicaid eligibility was later granted. His appeals to officials for redress were rebuffed because the method used to impoverish this near-millionaire was "legal."

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[57] The Medicaid applicant loans a sum of money to someone else, usually an heir, in exchange for a promise to repay the loan within a set length of time based on the actuarial life expectancy of the elder. The state uses standard life tables without medical underwriting which under-estimates life expectancies enabling relatively low monthly payments. Tom Conlon, Administrator of Long-Term Care and Adult Services, told us on July 7, 2009 that promissory notes are used in about five percent of the cases. Mr. Conlon reviews all cases involving promissory notes including 41 such cases received between January 1, 2009 and October 27, 2009. The average duration of these notes is about a year and the average amount around $80,000 according to Deborah Castellano, Chief Case Work Supervisor in an interview on October 28, 2009.

[58] The "reverse half-a-loaf" strategy replaced the notorious "half-a-loaf" strategy when the Deficit Reduction Act of 2005 (DRA '05) changed transfer of assets rules so that the eligibility penalty begins when the applicant applies for Medicaid instead of when the assets were transferred. In a "reverse half-a-loaf," Medicaid applicants, nearly always with the advice and counsel of a Medicaid planning attorney, divest half their otherwise nonexempt assets and loan the remainder, taking a promissory note. During the penalty period thus created by the asset transfer, the Medicaid applicant uses the proceeds from the promissory note to pay privately for care. The net effect is that the applicant becomes eligible for Medicaid in half the time with only half the penalty as otherwise and legally transfers half the assets to a selected beneficiary, usually an adult-child heir. In an interview on October 28, 2009, Medicaid eligibility workers estimated that five to ten percent of Medicaid LTC cases use the "reverse half-a-loaf" technique averaging between $40,000 and $150,000.

[59] Assets held in an irrevocable, income-only trust are excluded from the Medicaid LTC eligibility determination process. Tom Conlon, Administrator of Long-Term Care and Adult Services, told us on July 7, 2009 that he sees "lots and lots" of these, that they are "used to beat us" by "people with giant money" who transfer their assets into the trust five years before applying for Medicaid to avoid the transfer of assets penalty. He reviews all such cases and has received 111 covering the period from January 1, 2009 to October 27, 2009. Deborah Castellano, Chief Case Work Supervisor told us in an interview on October 28, 2009 that trusts are used to qualify for Medicaid LTC in "maybe five or ten percent of cases."

[60] One easy way to eliminate otherwise countable assets is to purchase exempt resources. This may involve home improvements or renovations worth tens of thousands of dollars. The Medicaid applicant may be advised to purchase home furnishings or a new car even if they will not live in the home nor drive the car personally. Medicaid planning attorneys maintain long check lists of exempt resources to help clients divert assets away from the Medicaid resource limit.

[61] The latter two Medicaid planning techniques were discussed above in the section on the home equity exemption.

Medicaid Estate Recovery

Medicaid's generous exemptions and exclusions of large assets--including a home, business, automobile, household goods, etc., as explained above--are intended to ease the financial burden of long-term care, but only to delay, not to replace personal responsibility for the cost.

Congress made it clear 27 years ago that "all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution."[62]

That was the justification given for Medicaid estate recovery when the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) allowed states to pursue recoveries on a voluntary basis.

In the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) Congress passed and then-President Clinton signed legislation that mandated recovery from their estates of Medicaid benefits correctly paid to long-term care recipients.

To this day, however, few states pursue estate recoveries effectively. Less than one percent of Medicaid nursing home expenditures nationwide are recovered from estates.
Oregon is an exception. It recovered 5.8 percent of its Medicaid nursing home expenditures from estates. Rhode Island recovered only 1.0 percent in the same year.[63]

Although Rhode Island's Medicaid estate recovery program recovered over $8 million in one past year, it brought in only $2 million last year, leaving at least $13 million unrecovered.[64]

In the absence of a strong estate recovery program, Medicaid operates essentially as free inheritance insurance for heirs. Beyond the loss of non-tax revenue, failure to recover fully from estates conveys a message to future generations that long-term care is not a personal financial responsibility for which one needs to plan and prepare.

Bottom Line on Medicaid LTC Eligibility

Medicaid eligibility for long-term care is easy to obtain. The average middle-class Rhode Islander qualifies financially without difficulty for Medicaid-funded long-term care. Couples receive additional protection against "spousal impoverishment." And even the affluent, who consult legal advisors, may often qualify quickly without first spending down significantly for their care. Most Rhode Islanders who receive Medicaid LTC benefits do not have to pay such benefits back from their estates.

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[62] *United States Code, Congressional and Administrative News, 97th Congress—Second Session— 1982, Legislative History (Public Laws 97-146 to 97- 248)*, vol. 2 (St. Paul, MN:, West Publishing), p. 814, cited in U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Treatment of the Home: Determining Eligibility and Repayment for Long-Term Care," Policy Brief no. 2, April 2005, p. 10, http://aspe.hhs.gov/daltcp/reports/hometreat.pdf.

[63] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief No. 6, September 2005, p. 8, http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf.

[64] If Rhode Island had recovered at the same rate as Oregon, its recoveries would have totaled approximately $13 million more. See Stephen A. Moses, "R.I. Medicaid has sprung a leak," *Providence Journal*, September 17, 2009, http://www.projo.com/opinion/contributors/content/CT_moses17_09-17-09_LDFNSTA_v11.3f8d9c3.html.

In addition to easy rules on income and assets, the eligibility determination process also facilitates qualification. At least 85 percent of applications are filed by someone other than the applicant and at least 60 percent of applications are processed without any face-to-face contact with the applicant.[65] Elder law attorneys prepare about 10 percent of the Medicaid LTC applications.[66]

Both deliberate and unintentional misrepresentation of the facts on applications concerning income and assets are commonplace. Eligibility workers told us they don't have any means to go after people who lie. "Medicaid assistance is a freebie," one said. The only consequence is maybe ineligibility, but only if they're caught. This affects "maybe 5% of cases, but we don't really know."[67]

The eligibility workers also told us "Some social workers don't think it is their job to investigate. Whether you qualify for assistance depends on the 'luck of the draw' of who does your application."[68] In other words, some workers are stricter than others. Some do more investigation than others. The eligibility rules are so complicated and flexible, and assets are so difficult to prove, that a lot depends on the individual worker, the workload, and time available.[69]

"Eligibility technicians" review the "social caseworkers'" original eligibility determinations and conduct annual re-determinations of eligibility. They complained the state has no mechanism to follow up on and enforce negative redeterminations. If they close a case, the nursing homes complain and the families call their state legislators. Sometimes relatives bring an elder to Rhode Island, qualify them for Medicaid LTC, and then, when the time comes for redetermination, the family can not be found to re-verify eligibility.[70]

Eligibility policy staff and workers expressed frustration at Medicaid rules that make it hard for genuinely needy people to qualify but facilitate eligibility for affluent applicants who can afford legal advice to obtain Medicaid benefits without spending down their wealth. "You're the first person ever to ask our opinion at this level and want to know the answer," said one of seven eligibility workers to general assent.[71]

Now we can return to the questions we asked earlier and answer them.

Does LTC Rebalancing Save Money?

Rhode Island's "global Medicaid waiver" enables the state to offer more home care (people want) and less nursing home care (they don't want) by loosening certain federal constraints in exchange for the state's accepting a cap on federal matching funds.

But will it save money?

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[65] Interview with Tom Conlon, Administrator of Long-Term Care and Adult Services, on July 7, 2009.
[66] Interview with Deborah Castellano, Chief Case Work Supervisor on October 28, 2009.
[67] Based on an interview with seven Medicaid "social workers" and supervisors on October 28, 2009.
[68] *Ibid.*
[69] Nursing home representatives told us something similar: "No one knows what the [Medicaid eligibility] rules are. Attorneys get into the game to manipulate them. Rules should be uniformly applied, but if one of our residents goes to an office and another goes to a different office, they get totally different answers regarding eligibility." (Meeting with members of the Rhode Island Health Care Association on July 8, 2009.)
[70] Based on an interview with three eligibility technicians averaging over seven years of experience on December 1, 2009.
[71] Based on an interview with seven Medicaid "social workers" and supervisors on October 28, 2009.

Saving money by "rebalancing" from institutional care, with its economy of scale, to home and community-based care, with its fragmented, labor-intensive services, is dubious.[72] Most research has shown for decades that home care delays but does not replace nursing home care.[73]

While individual lower-acuity patients may be cheaper to care for in the community than in a nursing home initially, across lifetimes and across populations, long-term savings are highly doubtful.[74]

In fact, no state Medicaid program has yet reduced combined institutional and non-institutional LTC expenses over time.[75] Nursing home expenditures flatten or even decline but home care costs skyrocket.[76]

This is true already even though the long-anticipated baby-boom "Age Wave" in America and Rhode Island has barely begun and will soon explode.[77] RI's population of age 85 plus, the cohort most likely to need LTC is projected to increase by 46 percent, from 25,000 to 37,000 individuals between 2007 and 2030.[78]

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[72] "[A]analysis of the health conditions of nursing home residents found that Rhode Island has a substantially lower percentage that are considered low care than is the average nationwide. This suggests that there are significant challenges ahead for the state's ongoing efforts to transition more beneficiaries residing in nursing homes back into the community." ("Future of Medicaid," *op. cit.*, p. 44, footnote omitted)

[73] "When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care." (General Accounting Office, "The Elderly Should Benefit From Expanded Home Health Care But Increasing Those Services Will Not Insure Cost Reductions" (Dec. 7, 1982) p. 43, http://archive.gao.gov/f0102/120074.pdf.)

[74] "An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that noninstitutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations." (John F. Holahan and Joel W. Cohen, *Medicaid: The Trade off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986, p. 106.)
"Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective." (Kenneth G. Manton, "The Dynamics of Population Aging: Demography and Policy Analysis," *The Milbank Quarterly*, Vol. 69, No. 2, 1991, p. 322.)

[75] Some recent research makes the case that maybe someday funding more home and community-based care through Medicaid will save money: "Medicaid spending on home and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings." (H. Stephen Kaye, Mitchell P. LaPlante, and Charlene Harrington, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending?," *Health Affairs*, Vol. 28, No. 1 (2009), p. 262, http://content.healthaffairs.org/cgi/reprint/28/1/262).

[76] "While the majority of Medicaid long-term care dollars still go toward institutional care, the national percentage of Medicaid spending on HCBS has more than doubled from 19 percent in 1995 to 41 percent in 2007." (Kaiser Commission on Medicaid and the Uninsured, "Medicaid Home and Community-Based Service Programs: Data Update," November 2009, p. 1, http://www.kff.org/medicaid/upload/7720-03.pdf.)

[77] "At the present time, Rhode Island's slow population growth has effectively limited the impact that enrollment has in driving expenditures, at least based on present eligibility standards. . . . There is evidence, however, that the aging of the population will have a significant impact on Medicaid costs beginning in 2013, as the majority of baby boomers reach 65. . . . Within a decade of 2012, the U.S. Bureau of Census estimates there will be an additional 11,600 elderly individuals over the age of 75 in Rhode Island. The need for long-term care and end-of-life care is expected to increase proportionally as more and more aging baby boomers become what is often referred to as 'the oldest of the old' - i.e., age 75 and older. The available data on Medicaid in Rhode Island today indicates that the oldest of the old is both the largest and highest cost group of beneficiaries within the elderly population." ("Future of Medicaid," *op. cit.*, pps. 57-58)

[78] Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 272,

Nevertheless, making more home and community-based long-term care available to more people is unquestionably desirable. So, whether it costs less or not, we should focus on how to pay for it, either publicly, privately or both.[79] But how to pay for home and community-based care deserves far more attention than it has received so far.

The Woodwork Effect

The practical problems of providing long-term care in the home and community are perhaps not the biggest risk of potential cost over-runs.

Public officials should also consider the possibility that offering services that people want more than nursing home care may increase demand. This is the familiar problem of the "woodwork" effect.

For every person in a nursing home, two or three are managing at home with equal or greater disability--half of whom are bedbound, incontinent or both--because of heroic efforts made by their loved ones, mostly women--wives, daughters and daughters-in-law---to keep them out of nursing homes.[80]

The state of Rhode Island under its global Medicaid waiver is not only making more desirable Medicaid-financed services available, it is changing the clinical and financial eligibility rules to make home care services easier and nursing home care more difficult to obtain.

It is also important to remember that Medicaid eligibility often includes coverage of medical services seniors need that Medicare does not cover. The state's Medicaid eligibility policy specialist told us: "Rhode Island covers almost every medical need known to man, including heart transplants. Everyone wants to move to this tiny state."[81]

In combination and over time as the public becomes aware of them, these benefits and initiatives are likely to increase the demand for Medicaid-financed long-term care, enhance the market for Medicaid planning (artificial impoverishment) to qualify for Medicaid, and reduce the public's sense of urgency about responsible LTC planning through savings, investment or insurance.[82]

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http://www.aarp.org/research/ppi/ltc/Other/articles/across_the_states_2009__profiles_of_long-term_care_and_independent_living.html, cited December 9, 2009.

[79] "Increased financing for HCB services may be desirable but will not significantly influence nursing home expenditures. . . . We must seek to justify HCB on grounds other than cost effectiveness or clinical efficacy: the debate should focus on how much community care we are willing to purchase as a society, rather than how much money we can save by purchasing these services." (Diane Dion Hallfors, "State Policy Issues in Long-Term Care for Frail Elders," Center for Vulnerable Populations, Institute for Health Policy, Brandeis University, Mar. 30, 1993, p. 8.)

[80] "...75% of LTC is given by family members, and...one-half of the patients so helped are bedbound or incontinent or both." (William E. Oriol, *The Complex Cube of Long-Term Care*, American Health Planning Association, Washington, D.C., 1985, p. 210.) Little has changed since 1985: "*The community-based disabled population is sizeable*. In 2002, about 8.7 million people age 65 and older living at home, or 26.5 percent of the population, reported some type of disability that limited their ability to perform basic personal activities or live independently. About 6.1 percent, or 2.0 million people, were severely disabled. By comparison, about 1.4 million older people lived in nursing homes in 2002." (Richard W. Johnson and Joshua M. Wiener, "A Profile of Frail Older Americans and Their Caregivers," Occasional Paper Number 8, Washington, DC, February 2006, p. vii, http://www.urban.org/UploadedPDF/311284_older_americans.pdf, emphasis in the original.)

[81] Interview with Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services on July 7, 2009.

[82] The fact that offering more home and community-based care induces greater Medicaid dependency is nothing new as this quote from leading LTC scholars attests. "Given a choice between nursing home care and nothing, many elderly will choose nothing. But when the choice is expanded to include home care, many will choose home care. Thus, the costs associated with large increases in home care more than offset small reductions in nursing home use." (Joshua M.

Are these extra loads[83] on already scarce public resources[84] an added responsibility state officials are prepared to assume?[85]

Is that wise during a recession,[86] with state deficits rising,[87] and under a program in which federal matching funds are already capped by the global waiver?[88]

What if the recent massive infusion of supplemental federal Medicaid matching funds that has brought $300,000,000[89] to the state this year[90] terminates as scheduled at the end of 2010?[91]

Wiener and Katherine M. Harris, "Myths & Realities: Why Most of What Everybody Knows about Long-Term Care Is Wrong," *The Brookings Review*, Fall 1990, p 32.)

[83] Rhode Island has already taken strong measures to offset current budget shortfalls including the diversion of supplemental federal Medicaid matching funds, elimination of health coverage for 1,000 low-income parents, and requiring low-income elderly people to pay more for adult daycare. (Nicholas Johnson, Phil Oliff, and Jeremy Koulish, "An Update on State Budget Cuts," Center on Budget and Policy Priorities, Washington, DC., revised May 13, 2009, http://www.cbpp.org/files/3-13-08sfp.pdf, cited December 10, 2009.)

[84] "As a state Senate panel studies the problems facing the 24 municipal-employee plans in Rhode Island, state Auditor Ernest Almonte testified that they now have a combined unfunded liability of $1.7 billion, something he called 'very devastating.' Add state-employee and teacher pensions, and some believe that Rhode Island faces a debt of about $7 billion." (_____, "Editorial: R.I.'s Pension Pickle," *Projo.com*, December 13, 2009, http://www.projo.com/opinion/editorials/content/ED_pensions13_12-13-09_5QGNFM9_v47.3f8c37f.html, cited January 8, 2010.)

[85] "Since SFY [State Fiscal Year] 2001, the state of the Rhode Island has faced the dilemma of structural budget deficits. All indications are that these deficits are likely to continue going forward. The state budget office forecasts annual deficits in excess of $350 million dollars per year for next five years; cumulative out-year deficits total an estimated $1.577 billion (Figure 37) [omitted]. Given the size of the Medicaid program, and its impact on the state budget, Medicaid will be a contributing factor to the size of the deficit and to any actions the state pursues to close the gap between the increase in growth in revenues and expenditures for many years to come." ("Future of Medicaid," *op. cit.*, p. 55)

[86] "The deepening financial crisis is expected to impact the ability of many states to provide both acute and long-term care Medicaid services to the growing number of individuals eligible for Medicaid." (Terence Ng, Charlene Harrington, and Molly O'Malley, "Medicaid Home and Community-Based Service Programs: Data Update," Kaiser Family Foundation, December 2008, p. 1, http://www.kff.org/medicaid/upload/7720_02.pdf, cited December 9, 2009.)

[87] The Kaiser Family Foundation's StateHealthFacts.org website reports that Rhode Island faces a mid-year 2010 budget shortfall of $200,000,000. (Kaiser Family Foundation, StateHealthFacts.org, "Rhode Island: State Budget Shortfalls, SFY2010," http://www.statehealthfacts.org/profileind.jsp?rep=49&cat=1&rgn=41, cited December 10, 2009.)

[88] "The country's smallest state has big problems. It was one of the first states to fall into the recession because of the housing crisis and may be one of the last to emerge. Rhode Island consistently ranks near the top of states with the highest unemployment rates, and last year it had the highest home foreclosure rates in all of New England. State government has a poor record of managing its finances, and its economic recovery is hampered by high tax rates, persistent state budget deficits and a lack of high-tech jobs." (The Pew Center for the States, "Beyond California: States in Fiscal Peril," November 2009, p. 4, http://www.pewcenteronthestates.org/uploadedFiles/wwwpewcenteronthestatesorg/BeyondCalifornia.pdf, cited December 9, 2009.)

[89] $300,000,000 is an estimate provided by Ann Martino, Director of Policy, Executive Office of Health and Human Services, in an interview on December 3, 2009. For a detailed analysis and estimate, see State of Rhode Island Senate Budget Office, Senate Fiscal Staff, and House Fiscal Staff, "The American Recovery and Reinvestment Act of 2009: Rhode Island Impacts and Opportunities," revised March 5, 2009, http://www.budget.ri.gov/Documents/arra/2_ARRA%20of%202009%20-%20Rhode%20Island%20Impacts%20and%20Opportunities%20Rev%203-5-09.pdf.

[90] "Were it not for the enhanced federal matching funds the state received under the ARRA, meeting the expectations in the SFY 2009 and SFY 2010 budgets would have required dramatic reductions in both eligibility and the scope of services provided to Rhode Island's Medicaid beneficiaries." (Executive Office of Health and Human Services, "Rhode Island Annual Medicaid Expenditure Report - State Fiscal Year 2008," undated, quoted from Secretary Gary Alexander's cover message, http://www.ohhs.ri.gov/documents/documents09/RI_Medicaid_Expend2008_final.pdf.)

[91] The U.S. House of Representatives has passed an extension of the supplemental FMAP through June 30, 2010 as part of the "jobs bill" (HR 2487). The U.S. Senate is expected to consider the jobs bill in January 2010. If passed, this legislation would give states a six-month reprieve from the termination of supplemental Medicaid matching funds.

How to Avoid the Pitfalls of Rebalancing

All of these problems are manageable if and only if Rhode Island Medicaid reconfigures LTC financial eligibility to target the program's limited resources to people most in need.

It must also incentivize others, who remain young, healthy and affluent enough, to plan early for long-term care and save, invest or insure privately so they do not become a burden on the public program.

Currently, few Rhode Islanders purchase private long-term care insurance. Probably only one to five percent of eligible consumers have the coverage. The state's Long-Term Care Partnership program remains in limbo with very few policies having been sold.

Agents we interviewed attributed the lagging LTC insurance market to consumer "denial," ease of access to Medicaid-financed LTC, widely available Medicaid planning advice, and a shortage of insurance producers able to make a living while specializing in the product.[92]

Even fewer Rhode Islanders use reverse mortgages to fund their own home and community-based care before they turn to public assistance. Why do so when Medicaid exempts the home and home equity is easy to divert from estate recovery liability?[93]

Although federal law has mandated that state Medicaid programs recover the cost of their care from the estates of deceased recipients, Rhode Island has a very limited estate recovery program and recovers only a fraction of the non-tax revenue it could receive with more robust efforts.

This report's recommendations will describe measures the state should take to target scarce Medicaid resources to people most in need and to encourage others to prepare to pay privately for long-term care with savings, home equity, other investments or long-term care insurance.

Rhode Island's unique global Medicaid waiver may allow needed changes to be made that would be prohibited everywhere else in the country in the absence of such a waiver.

Impact of Rebalancing on Skilled Nursing Facilities

The second practical question we need to address is: How will nursing homes adapt to losing their lower acuity (i.e. more profitable) residents? The answer is: Nursing homes can adapt only with great difficulty.

Rhode Island Medicaid already reimburses nursing homes less than the cost of providing the care: $18.80 per bed day under allowable costs projected for 2009.[94] At $173 per day, Rhode Island's Medicaid nursing home reimbursement rate is only 70 percent of the private pay rate ($248).[95]

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[92] Based on meetings with long-term care insurance experts on July 10, 2009; with the principal LTC insurance regulator, Rate Analyst Philip Sheridan on July 9, 2009; and on the minutes of a "Long-Term Care Insurance Partnership Workgroup" meeting held on November 10, 2009.

[93] Based on feedback from a meeting with reverse mortgage specialists on July 10, 2009 and email follow up with Brenda J. Archambault and Bill White (see list of Respondents and Interviewees). All agreed Medicaid's $500,000 home equity exemption tends to crowd out the use of reverse mortgages to fund LTC.

[94] ELJAY, LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," for the American Health Care Association, November 2009, Table 1, p. 7, http://www.ahcancal.org/research_data/funding/Documents/2009%20Medicaid%20Shortfall%20Report.pdf, cited December 9, 2009.

At a meeting with members of the Rhode Island Association of Facilities & Services for the Aging, the provider trade association representing mostly non-profit members, we were told "Medicaid reimbursement doesn't come close to covering our costs. We have to fund-raise, write grants, and depend on other payers. We try to get more private payers. We pay a 'provider tax' of 5.5 percent."[96]

Nevertheless, Rhode Island has managed to maintain a reputation for quality nursing home care. A recent Government Accountability Office (GAO) study found that RI was one of only eight states in the country with zero poor-performing nursing homes.[97]

By changing to acuity-based reimbursement and tighter clinical eligibility standards, the state could place financial pressures on nursing homes that force staff reductions and impair quality of care for the highest-need patients who remain in skilled facilities.[98]

"Take away dollars and you take away care," said Angelo S. Rotella, Esq., a Rhode Island provider and Past Chair of the American Health Care Association, a national LTC provider trade association comprised mostly of for-profit facilities.

"When home and community-based services are not available, and nursing homes are not available, what is the solution? Waiting lists," we were told at a meeting with members of the Rhode Island Health Care Association.[99]

To avoid such an outcome, policy makers need to understand how it happened that people who don't necessarily need 24-hour-a-day skilled nursing care came to receive long-term custodial care in nursing homes in the first place.

How Did Low-Acuity Medicaid Recipients End Up in Expensive Skilled Nursing Facilities?

It is a long, complicated story, but in a nutshell: Medicaid made nursing home care free or radically subsidized beginning in 1965. At first, there were not even restrictions on transferring assets to qualify. So virtually everyone qualified.

Families saw that placing their frail or infirm elder in a nursing home was free or very inexpensive while caring for the loved one at home was expensive and uncompensated by government.

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[95] Ari Houser, Wendy Fox-Grage, Mary Jo Gibson, "Across the States: Profiles of Long-Term Care and Independent Living," eighth edition, 2009, AARP, Washington, DC, p. 275, http://www.aarp.org/research/ppi/ltc/Other/articles/across_the_states_2009__profiles_of_long-term_care_and_independent_living.html, cited December 9, 2009.

[96] Meeting with members of the Rhode Island Association of Facilities & Services for the Aging on December 1, 2009.

[97] Russell J. Moore, "GAO says no Rhode Island nursing homes rate poorly," November 3, 2009, http://www.warwickonline.com/pages/full_story_news/push?article-GAO+says+no+Rhode+Island+nursing+homes+rate+poorly%20&id=4257805&instance=home_news_right, referring to United States Government Accountability Office, "Nursing Homes: CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit," pps. 13, 15, GAO-09-689, August 2009, http://www.gao.gov/new.items/d09689.pdf.

[98] Nursing home representatives we interviewed agreed that "rebalancing" is a good idea in principle, but expressed concern that despite their having higher acuity patients in the future, the new acuity-based reimbursement system allows for no more than a 1.1 percent increase in their reimbursements and could lead to as much as a 7.1 percent decrease.

[99] Meeting with members of the Rhode Island Health Care Association on July 8, 2009.

As a result, there was little private financing to build and sustain a home and community-based services infrastructure. Long-term care became equated with nursing home care in the public's mind. Few alternatives existed.

The nursing home industry accepted the new bonanza of Medicaid funding four decades ago and built new skilled facilities throughout the country. Early on, Medicaid's LTC reimbursements were lucrative and highly profitable.

But as Medicaid LTC costs exploded, government officials took dramatic measures to control nursing home expenditures.

First, they capped the supply of nursing home beds with Certificate of Need (CON) programs. But restricting supply, predictably increased prices. Nursing homes responded by charging state Medicaid programs more.

So, Medicaid capped reimbursement rates. That was the origin of the differential between high private-pay rates and low Medicaid rates. In Rhode Island, to this day, Medicaid reimbursement is only 70 percent of the private pay rate.

As the public came to realize that paying privately for long-term care was expensive and unnecessary, given Medicaid's generous and elastic LTC eligibility rules, more and more people converted from private pay to Medicaid.

As profitable private-pay revenue plummeted from half of nursing homes' receipts in the beginning to only about ten percent today, nursing homes were forced to economize in order to remain financially viable.

They had only two ways to reduce expenses and neither method was well-received by government and consumers:

If they cut costs for staff or services, nursing homes were accused of providing poor quality care.

If they tried instead to attract higher-paying private residents, they were accused of discriminating against Medicaid recipients.

In time, low Medicaid reimbursements and reduced private-pay revenue created a serious quality of care problem in nursing homes.

In the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), the federal government insisted on higher staffing, more training and better care in Medicaid and Medicare financed nursing homes.

But higher public reimbursements to finance the desired improvements were not forthcoming. Despite valiant efforts by nursing home providers to ensure quality care, low Medicaid reimbursements continue to be a severe handicap.

The main way nursing homes have managed through these last four decades of changes is that while their residents were mostly Medicaid and reimbursed therefore at minimal levels, they at least were the dominant venue of care so they had a mix of low-acuity, higher-profit residents to balance the cost of caring for their higher-acuity, less profitable residents.

By changing the rules so that nursing homes must treat increasing numbers of more demanding, less profitable, higher-acuity residents while they lose more of their less demanding, more profitable, lower-acuity residents, the state runs the risk of further crippling nursing homes' ability to provide quality care.

To make matters even worse, another key public funding source for nursing homes is also highly vulnerable. Nursing homes nationally receive 18 percent of their revenue from Medicare. Unlike Medicaid, Medicare pays very generously. Nursing homes make a profit on their limited Medicare business. They need that profit to counterbalance their losses on Medicaid residents.

But Medicare nursing home financing is highly vulnerable in the future. The program has an $89 trillion infinite-horizon unfunded liability.[100] MedPAC, the Medicare Payment Advisory Commission, advises Congress annually to curtail nursing home reimbursements.[101] So far, Congress has refused but the jaws of a fiscal vise are closing on Medicare inexorably.[102] It may not sustain nursing homes much longer in the absence of higher Medicaid or private pay revenues.

The Capacity Issue

The third practical question we raised is: Can the alternative care venues encouraged by the global waiver, such as adult day care, home care and assisted living, satisfy the extra demand for their services at rates Medicaid can afford to pay?

Speaking to the purveyors of home and community-based services in Rhode Island left us with an ambiguous answer to that question--"maybe"--with many qualifications.

Adult day care providers told us their service is disadvantaged under Medicaid because they receive a single flat fee of $52.98 per day although it costs $100 per day to serve some of their participants. They have no incentive to serve higher acuity Medicaid recipients.[103]

Home care providers told us they'll need to see just how high-acuity the new patients diverted from nursing homes will be before they commit to providing services, even at the slightly increased, but still very low rates Medicaid is willing to pay.[104]

Assisted living facility providers told us only a couple facilities have been willing to participate because, with an average private pay rate of $4,500 per month, none of the three rates variously

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[100] Social Security and Medicare Trustees 2009 reports as cited in The Concord Coalition, *Facing Facts Quarterly*, Vol. 5, No. 3, p. 3, http://www.concordcoalition.org/files/uploaded-pdfs/FF_Newsletter_V-3_09-1206_1.pdf.

[101] MedPAC is likely to do so again soon: "The Medicare Payment Advisory Commission in a preliminary draft has recommended that skilled nursing facilities not receive a Medicare payment increase for 2011." (McKnights.com Weekly Roundup, December 18, 2009, http://www.mcknights.com/medpac-may-recommend-freezing-medicare-payments-for-skilled-nursing-facilities-for-2011/article/159519/?DCMP=EMC-MCK_Weekly).

[102] "About one in five nursing homes, hospitals and home care agencies could fall into the red as a result of Medicare cuts in the Senate healthcare reform bill, a new government study finds." (McKnights.com Weekly Roundup, December 18, 2009, http://www.mcknights.com/report-medicare-cuts-in-senate-bill-could-lead-to-earnings-losses-at-some-nursing-homes/article/159518/?DCMP=EMC-MCK_Weekly.)

[103] Meeting with members of the Rhode Island Association of Facilities & Services for the Aging on December 1, 2009.

[104] Meeting with Alan Tavares, Executive Director, R.I. Partnership for Home Care, on July 9, 2009. Mr. Tavares said home care has never been a major participant in Rhode Island Medicaid, only about 10 percent compared to 90 percent nursing home care. He's doubtful the home care proportion can increase significantly even with the recent increase in reimbursement to a maximum of $22.70 per hour, of which the caregiver gets only about $11. He's concerned about a "whole rash of agencies coming in figuring they're going to make a score on the global waiver."

available through Medicaid waivers in the past ($1,079, $1,700, or $2,011) covers costs.[105] "We see no incentive for assisted living to take a Medicaid client. The program does not even cover 50 percent of our costs."[106]

State Medicaid staff have approached the challenge of rebalancing LTC ingeniously. Medicaid has increased reimbursement to adult day care and home care providers. Assisted living providers are next in line for enhanced reimbursement.

Yet, to date, only approximately 80 people have been relocated from nursing homes to home and community-based placements since the program's inception in July 2009. Perhaps 150 in total have been diverted away from likely nursing home care into home care placements.

One sure way to increase and improve the supply of and access to all kinds of home and community-based services (HCBS) is to increase the level of private financing going to fund such services.

Unfortunately, for reasons already explained, increased public financing for HCBS through the global Medicaid waiver tends to have the opposite effect, replacing market-rate private financing with disproportionately low Medicaid rates.

The solution is to attract more private financing to HCBS by ensuring that public financing of all levels of long-term care is targeted to people most in need and that people more able to pay privately are required to do so--either up front at the time they need care or later through recovery of Medicaid costs from liens or estate recoveries.

The Crowd-Out Effect

The fourth practical question we raised earlier is this: Will Medicaid's funding more of the services people prefer (home care) and less of the services they'd rather avoid (nursing home care) further discourage private LTC planning and financing leaving more and more of the cost of long-term care on public programs?

By now, the answer to that question is obvious and clear. Most Americans, including Rhode Islanders, don't worry about long-term care risk or cost until they face a crisis.

Once Dad has a stroke or Mom succumbs to Alzheimer's Disease, it's too late to save, invest or insure for long-term care.

Then the path of least resistance is to rely on Medicaid to finance the care. And if Medicaid will pay for home and community-based care, all the better.

In the absence of strong controls on financial eligibility to limit access to Medicaid LTC benefits in the first place, most people find easy ways to qualify as explained above.

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[105] Phone interview with Kathleen Kelly, Executive Director, Rhode Island Assisted Living Association on July 8, 2009. Ms. Kelly also explained that most of the people transitioned or diverted from nursing homes so far under the global waiver have gone into home care for which reimbursement rates have already been increased. Rate increases for assisted living are pending.

[106] Meeting with members of the Rhode Island Association of Facilities & Services for the Aging on December 1, 2009.

Without the certainty that Medicaid expenditures will be recouped after death from recipients' estates, the program operates in effect, if unintentionally, as free inheritance insurance for baby boomer heirs.

In fact, Rhode Island does not effectively recover from estates now leaving at least $13 million uncollected annually and probably more.

Thus, so long as most Rhode Islanders can ignore the risk and cost of LTC, avoid the premiums for private insurance, shelter their wealth including home equity, and rely on public financing if they ever need expensive LTC, it's easy to understand why so few of them save, invest or insure so they can pay privately for LTC when they need it and why so many of them end up dependent on the public welfare safety net.[107]

The Big Question

That leaves us with the final question to answer:

What can policy makers do to ensure that care receivers, care funders, and care givers prosper and that quality long-term care at the most appropriate level is available to all even as the massive baby-boomer Age Wave finally crests and crashes on the state and the country?

Findings

Rhode Island Medicaid has embarked upon a financially risky, but potentially very beneficial reorganization of its long-term care delivery system.

State policy makers agree on the "Basic Principles" guiding their long-term care reform initiative:

1. "'Take care of the people with no other options first'
2. 'Right service, right setting, right time, right result'
3. 'For everyone a medical home with all the necessary information'
4. 'Leverage all available money'
5. 'Remember the taxpayer'"[108]

So far, Rhode Island's LTC reform measures have addressed two of those objectives (numbers 2 and 3) but largely disregarded three others (numbers 1, 4, and 5).

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[107] Low market penetration for private long-term care insurance in a state with generous access to Medicaid-funded LTC benefits comports with research findings that confirm the impact of Medicaid "crowd out." For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for *at least two-thirds and as much as 90 percent of the wealth distribution*, even if comprehensive, actuarially fair private policies were available." (Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf), emphasis added.

[108] "In assessing the prospects for the Future of Medicaid, there are a few key operating principles, derived from the findings of this study, that should be considered when weighing the options:
• 'Take care of the people with no other options first'
• 'Right service, right setting, right time, right result'
• 'For everyone a medical home with all the necessary information'
• 'Leverage all available money'
• 'Remember the taxpayer'"
("Future of Medicaid," *op. cit.*, p. 77)

The state's unique global waiver enables Rhode Island Medicaid to provide more LTC services in settings people prefer (home and community) and fewer in settings most people would rather avoid (nursing homes).

Thus, the principles of providing the right services in the right settings are being met.

In the absence of equally radical changes to Medicaid's generous financial eligibility for long-term care, however, the clinical changes implemented by Rhode Island could cause LTC expenses to skyrocket, waiting lists to explode, or both.

Easy access to Medicaid LTC eligibility after the insurable event has occurred increases public expenditures and crowds out potential private LTC financing sources.

Clearly, the objectives of caring first for the neediest, leveraging all available money, and remembering the taxpayers are not yet achieved nor even being strongly pursued.

To be sure, Rhode Island is constrained by generous and elastic, federally imposed LTC eligibility rules that prevent the state from targeting scarce Medicaid resources to people most in need.

It was precisely the domineering, over-restrictive federal laws and regulations governing waivers, home and community-based services, and institutional bias that Rhode Island sought to escape by means of its global Medicaid waiver.

So, the next logical step for Rhode Island is to seek authority under the global waiver to pursue Medicaid LTC financial eligibility rules that comport more fully with the state's principles of long-term care reform.

Recommendations

The following recommendations if implemented would position Rhode Island Medicaid to achieve all of its remaining LTC reform goals by (1) targeting scarce public resources to people most in need and (2) attracting nontax revenue to LTC financing from private assets, home equity and insurance, thus (3) relieving the financial burden of Medicaid LTC on taxpayers.

If some of these recommendations seem harsh, consider them in the context of what will happen when Medicaid and other state and federal safety net programs are unable to continue supporting current programs. Consider the potential benefits to all concerned--care receivers, caregivers, and care funders--of attracting new sources of private financing to the long-term care system.

I. Establish a baseline. Study a valid random sample of LTC cases to determine how much money Rhode Island Medicaid loses because of . . .

1. Assets transferred before the five-year transfer of assets look-back period.
2. The $500,000 home equity exemption.
3. The business exemption.
4. The automobile exemption.
5. The prepaid burials exemption.
6. The term life insurance exemption.
7. The household goods exemption.
8. Purchase of exempt assets.

9. The "reverse half-a-loaf" technique.
10. Irrevocable income-only trusts.
11. Medicaid friendly annuities.
12. Life estates with special powers.
13. Purchase of an interest in another's home.
14. Fraud or unintentional misrepresentation of personal finances.
15. Other Medicaid planning techniques.
16. Failure to pursue TEFRA liens.
17. Lack of a robust Medicaid estate recovery program.

The results of this study should provide ample evidence of the need for and the benefits of implementing the remaining recommendations.

II. Seek authority from the federal Centers for Medicare and Medicaid Services under the state's global Medicaid waiver[109] to change Rhode Island's financial eligibility rules for long-term care services in the following ways.[110]

1. Extend the look-back period during which assets transferred for less than fair market value to qualify for Medicaid incur an eligibility penalty from five years (currently) to ten years (as currently in Germany, a socialized health care system.)
2. Eliminate or radically reduce the home equity exemption for Medicaid LTC eligibility from $500,000 (currently) to no more than $40,000 (as in the United Kingdom, another socialized health care system.)
3. Preclude the use of trusts, annuities, promissory notes, the "reverse half-a-loaf" strategy and other Medicaid planning techniques to divest or shelter assets from Medicaid LTC financial eligibility limits.

III. Enhance Rhode Island's lien and estate recovery program.

1. Establish a TEFRA lien program and make it stronger than otherwise allowed under federal law by using the global Medicaid waiver authority.
2. Hire more estate recovery personnel until the marginal rate of return is reached, i.e. add staff as long as each new hire increases lien and estate recoveries.
3. Establish a system, currently nonexistent, to ensure that every death of a Medicaid LTC recipient is reported immediately and that the estate recovery procedure begins without delay in every case with potentially recoverable assets.
4. Seek passage of the "uniform probate code" by the state legislature.[111]
5. Expand estate recovery to include home care, not just nursing home services as currently.

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[109] Rhode Island's global Medicaid waiver document and the CMS approval letter are accessible online here: http://www.eohhs.ri.gov/medicaid/pdf/GlobalWaiverFinal1-09.pdf.

[110] We have made the case in this report that in order to achieve the rebalancing goals of the global waiver cost-effectively, Rhode Island will need to change financial eligibility rules to discourage over-utilization of Medicaid LTC services. But does the global waiver allow the state flexibility to make such changes? Arguably, it does not. Page 21, items 23 and 24, of the waiver document state explicitly that "Eligibility determinations for ABD [aged, blind and disabled] related populations in the community must follow the income and resource methodologies of the SSI program and the current Medicaid State Plan" and "In determining eligibility for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan." Nevertheless, state Medicaid management staff expressed the opinion that the global waiver gives them the right at least to ask for these additional authorities.

[111] "The **Uniform Probate Code** (commonly abbreviated **UPC**) is a uniform act drafted by National Conference of Commissioners on Uniform State Laws (NCCUSL) governing inheritance and the decedents' estates in the United States. The primary purposes of the act were to streamline the probate process and to standardize and modernize the various state laws governing wills, trusts, and intestacy." (Wikipedia, cited January 8, 2010, emphasis in the original.)

6. Seek state legislative approval of the expanded definition of probate to include assets passed in joint tenancy with right of survivorship as authorized by OBRA '93.
7. Track and seek recoveries from the estates of deceased spouses for Medicaid's cost of care paid for their predeceased spouses on Medicaid, AKA "spousal recoveries."
8. Track and seek recoveries from former Medicaid recipients who die after leaving Medicaid.
9. Seek state legislative authority to capture accounts held by nursing homes in the Medicaid recipients' names until estate liability is determined.
10. Establish a system to recover hard assets, including investment-grade property, from recipients' estates before the property is taken by heirs.
11. Set up repayment plans whereby families can repay their estate recovery liability over time and retain ownership of homes or other property if they wish.
12. Conduct a study of successful estate recovery programs, especially Oregon's, and implement best practices. Seek state legislative authority for changes that require it.
13. To eliminate all cost to the state and maximize recoveries, consider hiring an outside contractor on contingency to do estate recoveries in exchange for a percentage of the amount recovered.

III. Educate Rhode Islanders about the importance of planning for long-term care.
1. Explain the risk and cost of long-term care in the media and in public meetings.
2. Publicize what the state will and will not pay for and for whom under new, stricter eligibility rules.
3. Describe measures taken to restrict access to Medicaid LTC and why they are necessary to ensure access to quality care for the needy, as public funds diminish.
4. Emphasize the fact that stronger lien and estate recovery rules will ensure everyone who can pay will pay for long-term care, either up front as a private payer or after the fact, through Medicaid estate recovery.

IV. Implement measures to encourage the use of reverse mortgages and private long-term care insurance to fund long-term care privately.
1. Consider both tax and Medicaid eligibility incentives to promote the use of reverse mortgages to fund long-term care privately.
2. Consult the National Council on the Aging's (NCOA) report titled "Use the Home to Stay at Home" for additional ways to encourage the use of home equity conversion to fund LTC.
3. Publicize and expand Rhode Island's Long-Term Care Partnership program.
4. Consider and implement tax incentives to encourage the purchase of private long-term care insurance.

Why not try these measures in a small state that has already embarked on Medicaid experimentation with its global waiver? If they work, Rhode Island Medicaid could become a model for LTC reform throughout the country.

It happened for welfare reform when an experiment in Wisconsin went national in the Welfare Reform Act of 1996. It must happen for long-term care somewhere soon, because the Age Wave will make fixing long-term care harder and harder as time goes on.

Carpe diem.

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Respondents and Interviewees

Gary Alexander, Secretary of the Rhode Island Executive Office of Health and Human Services

Brenda J. Archambault, V.P. Mortgage Lending, The Washington Trust Company (reverse mortgage expert)

Deb Barclay, Administrator of Legal Services and Administration, Executive Office of Health and Human Services, Department of Human Services

Senator David E. Bates, Senate Minority Whip, State of Rhode Island Senate

Deborah Beards, Mount St. Rita Health Centre, Cumberland, RI

Deborah B. Buffi, Esq., Associate Director, Management Services, Executive Office of Health and Human Services, Department of Human Services

Virginia Burke, Executive Director, Rhode Island Health Care Association and several of her members

Dave Burnett, Associate Director of Government and Public Affairs, Executive Office of Health and Human Services

Frank T. Caprio, State Treasurer, Democratic candidate for Governor, 2010

Deborah Castellano, Chief Case Work Supervisor, Department of Human Services

Cynthia Conant-Arp, Executive Director, Hope Alzheimer's Center, Cranston, RI

Tom Conlon, Administrator of Long-Term Care and Adult Services, Department of Human Services

Karen Chludenski, Long Term Care Advisor, EmPower Services, Inc. (LTC insurance expert)

Dana Denman, Social Case Worker 1, Department of Human Services

Ted Dobek, Casework Supervisor, Department of Human Services

Marilee Driscoll, Speaker, Marketing Consultant, Author and Founder of LTCMonth.com

Robert "Bob" Fain, Professional Speaker, The Owl Nose (LTC insurance expert)

Bill Felkner, President, Ocean State Policy Research Institute

W. Christopher Fisher, Insurance Planning, (LTC insurance expert)

Carol Grilli, Eligibility Technician, Department of Human Services

Hugh J. Hall, Administrator, West View Health Care Center, president of the Rhode Island Health Care Association

Kathleen Heren, Associate Director and Clinical Director, Alliance for Better Long Term Care, LTC Ombudsman

Steven H. Jennings, Certified College Planner, National Collegiate Advisors

Kathleen Kelly, Executive Director, Rhode Island Assisted Living Association

Kelly Lee, Executive Director, Westerly Adult Day Services, Westerly, RI

Michael G. Leonardo, CFS, Financial Advisor, Ameriprise Financial

Susan A. Leone-Pomfret, Northeast Wholesale Account Executive,
MetLife Home Loans (reverse mortgage expert)

Greg Luttge, Eligibility Technician, Department of Human Services

Karl Lyon, long-term care (nursing home, assisted living and home care) provider

Mario Macera, CFO, Saint Antoine Residence, North Smithfield, RI

Senator Francis T. "Frank" Maher, Jr., Deputy Minority Leader, Rhode Island Senate

Ann Martino, Ph.D., Director of Policy, Executive Office of Health and Human Services

Ellen Mauro, Administrator, Office of Institutional and Community-Based Services and Supports, Department of Human Services

Lisa McAree, CLU, LTCP, President, The McAree Company (LTC insurance expert)

Ariel Mota, Eligibility Technician, Department of Human Services

Diane Nawrocki, Supervising Eligibility Technician, Department of Human Services

Elena Nicolella, Medicaid Director, Department of Human Services

James P. Nyberg, Director, Rhode Island Association of Facilities & Services for the Aging and 10 or 15 of his members

Ray Paola, Director of Long Term Care Insurance, Brokers Service Marketing Group

Joyce Paterson, Social Case Worker, Department of Human Services

Lynn Pohl, LTC Planning Specialist, Genworth Financial

Elizabeth H. Roberts, Lieutenant Governor, State of Rhode Island and Providence Plantations

Jane Rogers-King, Social Case Worker, Department of Human Services

Doug Ross, President, EmPower Services, Inc. (LTC insurance expert)

Angelo S. Rotella, Esq., Past Chair of the American Health Care Association

Philip A. Sheridan CLU, CIE, Senor Insurance Rate Analyst, State of Rhode Island Department of Business Regulation, Division of insurance

Rory Smith, former Republican candidate for Governor, 2010

Janice Stenson, Social Caseworker, Department of Human Services

Jill E. Sugarman, Esq., McLaughlin & Quinn, LLC, Attorneys at Law, elder law attorney and Medicaid planner

Susan Sweet, Sweet and Associates, Consultants, LLC

Alan Tavares, Executive Director, R.I. Partnership for Home Care

Mary Beth Vitullo, Social Case Worker, Department of Human Services

William K. "Bill" White, President, Ocean State Reverse Financing, Inc. (reverse mortgage expert)

Jennifer L. Wood, Chief of Staff and General Counsel, State of Rhode Island and Providence Plantations

J. Chris Woulfe, Executive Director, Scandinavian Home, Cranston, RI

Appendix: Recognition of Donors

The project concluded with this report began last Spring when Ocean State Policy Research Institute (OSPRI) president William Felkner contacted Center for Long-Term Care Reform (CLTCR) president Stephen Moses about conducting an analysis of Rhode Island's global Medicaid waiver.

The two agreed to seek funding for a study. In the end, OSPRI raised financing to support the work. But to get the process started, CLTCR reached out to its members for special contributions to "prime the pump." The purpose of the following list is to acknowledge the people and/or companies that provided that critical start-up funding which enabled the project to start.

The following individuals and/or their companies contributed financially to support our work on this project in Rhode Island.

Keystone ($5,000): Thomas Campbell Jackson

Foundation ($1,000 to $500): Rick Leonard and Joe Lautiero (Long Term Care Resources); Sue Howarth; Tom McAuliffe; Mark Randall (GoldenCareUSA); Phillip Sullivan; Stephen Forman (Long Term Care Associates, Inc.); Tony Stratidis

Building ($300 to $50): Bob Callanan; Claude Thau; Bill Dorfii; Eve Anderson; Alan Jonas; B.J. Randolph; Teresa Eagan; Sally Leimbach; Honey Leveen; Kyle Hitt; Annemiek Storm; Heady Nezhadpour.