Long-Term Care:

Principles, Policies, Proposals, and Petitions

Presented by the

Center for Long-Term Care Reform

"Dedicated to ensuring quality long-term care for all Americans"

Public Release Date: December 13, 2024

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Abstract

The challenge to provide and fund long-term care (LTC) for a rapidly aging population confounds scholars and policymakers. America's current LTC system is expensive, dominated by public financing, and heavily regulated, but it fails to deliver the kinds and quality of care consumers prefer. Unintended consequences of well-intentioned public policies account for this poor outcome. In 1965, Medicaid funded LTC for everyone "whose income and resources are insufficient to meet the costs of necessary medical services … ." This open-ended LTC funding source caused excessive utilization of Medicaid LTC benefits, unleashed explosive public spending, obviated the need for people to plan for LTC risk and cost, led to cost control measures that caused access and quality problems, resulted in low provider reimbursements that created caregiver shortages, and impeded the development of the home and community-based services options consumers prefer. To reverse these negative outcomes and deliver an affordable LTC system that provides the care people want in the venues they prefer, Medicaid must (1) pay LTC providers market rates, (2) limit eligibility to the needy who have actually spent down private income and resources for medical or LTC expenses, (3) cover the full range of LTC services and venues, (4) ensure access and quality across the care continuum, (5) regulate minimally relying primarily on market competition to ensure quality, and (6) focus LTC spending back onto the aging and disabled instead of the young and able. Reconfiguring Medicaid around these public policy objectives will achieve the positive results described and explained below.

LTC is Crucial

Long-Term Care, also known as long-term services and supports (LTSS), encompasses the medical and custodial assistance that aged and disabled people need due to chronic illness, frailty, or cognitive impairment. America's rapidly aging population creates a growing demand for LTC. In 2021, the U.S. spent $467 billion on LTC.[1] Public programs (71.4 percent), mostly Medicaid (44.3 percent) and Medicare (19.8 percent), are the biggest LTC payers. Private out-of-pocket spending was only 13.6 percent. Most of that came from income (largely Social Security) of people already receiving Medicaid LTC benefits, not from savings.[2] Medicaid-financed LTC already consumes .62 percent of GDP and is expected to use up 1.25 percent by 2050.[3] In 2031, the country's giant baby boom generation begins turning 85, the age at which medical and LTC needs spiral upward.[4] LTC expenditures explode thereafter simultaneously with senior entitlements like Medicare and Social Security facing insolvency.

LTC is Dysfunctional

Despite (or because of) these large public expenditures, America's LTC service delivery and financing system already suffers many negative outcomes. Consumers prefer to age in place, but 710,000 face waiting lists for Medicaid-financed home care.[5] Nursing homes and home care providers struggle to attract enough caregivers and turnover is high.[6] The media report serious access and quality problems especially in care venues that are more dependent on Medicaid.[7] Provider reimbursement levels are low, often less than the cost of providing the care.[8]

Discrimination prevails in favor of private payers and against Medicaid recipients because the former pay on average 150 percent of the latter.[9] Notwithstanding this huge, mostly publicly financed long-term caregiving infrastructure, unpaid family and friends provide most LTC at tremendous personal financial and emotional distress.[10] What accounts for this massive disconnect between America's large financial investment in LTC and these disappointing results?

Policies Matter

Public policy making is a powerful tool in the hands of lawmakers and government officials. Few areas of human wellbeing have been as heavily impacted by government policies as LTC. Arguably, well-intentioned policies, laws, and regulations over the past six decades combined to create the problems LTC faces today. This paper takes an in-depth look at six crucial LTC policy areas. It suggests a widely acceptable principle that should guide each policy, identifies the policies that government employed instead, including their unfortunate results, and proposes new ways to improve efficiency, empower consumers, and minimize distortions that cause wasteful, unhelpful or counterproductive expenditures.

So much of what passes for LTC policy analysis today involves tinkering with the existing highly defective service delivery and financing system. Analysts identify and bewail the system's malfunctions. But they routinely recommend more government spending and regulation without first asking and answering the critical question: what caused these problems in the first place? The Paragon Health Institute took a different tack. "Long-Term Care: The Problem" identified the cause of LTC's problems as excessive government funding and regulation. "Long-Term Care: The Solution" proposed policies to wean the LTC market off Medicaid dependency and to unleash the private market's potential to improve service delivery and financing.

The current paper asks and answers what an ideal market-based LTC services and financing system would look like. What **principles** should public policy follow? Which **options** are available? Do current **policies** violate preferred principles? Which **proposals** for change would achieve better results? How should we **petition** (ask for and justify) needed changes?

The Social Security Act (SSA) Set Big LTC in Motion

Medicaid's passage in 1965 supercharged LTC funding, corporatizing in a few years what had been a Mom and Pop business of residential care homes into a huge nursing home industry. To understand what transpired, we must examine the Social Security Act's Medicaid appropriation language.[11] SSA authorized Medicaid to provide medical assistance, rehabilitation and related services, including LTC, to individuals "whose income and resources are insufficient to meet the costs of necessary medical services … ." This open-ended authorization to fund LTC for everyone who cannot afford it set the stage for everything that followed in these six key policy areas:

(1) How and how much would Medicaid pay LTC providers?
(2) Who and how would people qualify for Medicaid LTC benefits?
(3) Which LTC services would Medicaid cover?

(4) Would Medicaid pay enough to achieve quality care or cope through regulation with the level of quality for which it would pay?
(5) How much regulation would be needed to ensure quality?
(6) Whom Medicaid benefits most, the young and able or the old and disabled?

How did Medicaid address each of these policy areas? What have been the consequences? And what needs to be done now?

Six Key Policies

(1) **Payment**

a. **Principle**: **Pay market rates.**

b. **Options**: By authorizing Medicaid to provide LTC to individuals "whose income and resources are insufficient to meet the costs of necessary medical services …," the SSA took on a potentially boundless financial responsibility for the program. It could pay market rates for the care or use a lower rate to constrain expenditures.

c. **Policies**: Initially, Medicaid did not stipulate a payment rate. States could pay what they wished, not to "exceed reasonable charges consistent with efficiency, economy, and quality of care."[12] After Medicaid LTC expenditures exploded in the early years, Congress mandated in 1972 that "all State Medicaid programs must pay nursing homes on a reasonable cost-related basis."[13] States deemed this policy restrictive and inflationary. So, the Omnibus Reconciliation Act of 1980's "Boren Amendment" allowed states to use less costly payment methods, provided they were "reasonable and adequate" to cover the costs of efficiently administered nursing homes.[14] In the end, Congress repealed the Boren Amendment in 1997 leaving no floor under state Medicaid LTC reimbursement rates.[15]

   Government health care price controls produce economic chaos.[16] To this day, Medicaid LTC reimbursement rates are only about 70 percent of private pay rates[17] resulting in serious market distortions, such as cost shifting to private payers, gradually disappearing private-pay revenue as patients migrate to Medicaid and discrimination against low-revenue-generating Medicaid recipients. Medicaid's sub-market payment rates also caused impaired LTC access and quality for recipients, caregiver shortages, decades of institutional bias to control costs, long HCBS waiting lists, Medicaid's reputation for sub-standard care, and excessive dependency on unpaid family caregivers who seek to avoid Medicaid dependency and its consequences.

d. **Proposal**: **Medicaid should pay market rates to LTC providers**. Market prices objectively and fairly balance supply and demand. Price data inform businesses and entrepreneurs which services consumers prefer and will reward with their custom. Market-based prices encourage experimentation, competition, and "creative destruction," as new and better companies succeed and older, worse ones fail. The

inevitable result is more and better care access and quality. If Medicaid paid market rates, the caregiver shortage problem, wrenching the field today, would disappear as LTC providers would be able to pay wages sufficient to attract adequate numbers of qualified staff. The discrimination against Medicaid payers and favoritism toward private payers that comes from Medicaid's paying reimbursement rates substantially below private-pay rates would also end. It is important to note that in the absence of artificial price suppression by government, market-based reimbursement rates will settle somewhere between current low Medicaid rates and excessively high private rates that were driven up by cost-shifting that will no longer occur in the absence of artificially low government-mandated rates.

e. **Petition**: Opponents of this policy will argue that Medicaid cannot afford to pay market rates. That is true as the program currently operates. But with many fewer Medicaid dependents and more private payers contributing toward total LTC costs, it would become feasible for Medicaid to pay market rates at total expenditure levels far below current ones. To reduce the number of people dependent on Medicaid for LTC substantially and to increase the number of private payers commensurately can be achieved through reform of the program's eligibility rules and policies as addressed in the next section.

(2) **Eligibility**

a. **Principle**: **Help the neediest only**.

b. **Options**: Medicaid's mandate to provide LTC to individuals "whose income and resources are insufficient to meet the costs of necessary medical services …" created the need to determine who qualifies for the help. How much income and resources would be "insufficient" to meet which LTC costs? The program could set strict, cost-effective income and resource limits. Or it could be more generous, incurring larger caseloads and costs. Policymakers chose the latter course.

c. **Policies**: Medicaid set and publicized very strict financial eligibility limits**.** Income above $943 per month or resources above $2,000 would be disqualifying. Left at those levels, fewer people would have qualified immediately and most would have had to pay their own way at private rates for a longer time before qualifying. LTC providers' ability to hire caregivers and supply high quality care would not have been as seriously impaired. Instead, Medicaid softened the financial eligibility criteria allowing high-income and high-asset people to qualify without their having to spend down savings significantly.

Medicaid allows applicants/recipients (A/Rs) to deduct private medical and LTC expenditures from their total income before having to meet the low-income ($943 per month) standard. That "medically needy" approach to income eligibility determination opened Medicaid LTC benefits to much higher income people with practically no upper limit.[18] It created a huge paperwork problem for A/Rs to accumulate and report proof of spending and for Medicaid programs to keep track.

But, at least, A/Rs had to verify that they spent down their excess income for qualified medical and LTC expenses. Thus income is a major financial contribution Medicaid ARs are required to make. If Medicaid were insurance, income would be its "deductible." The same personal financial contribution was not required or enforced for resources.

Instead of requiring A/Rs to spend down their savings for qualified medical or LTC services, as required for income, Medicaid allows resources to be expended for any good or service purchased at fair market value. In addition to $2,000 in "countable assets,"[19] A/Rs may retain unlimited exempt assets. As most large assets seniors own are exempt, including home equity, a business, a vehicle, IRAs, prepaid funeral expenses, personal belongings and home furnishings, middle- and upper middle-income people easily qualify based on resources. Any excess countable resources they retain can be converted to exempt status by purchasing a home improvement, a new car, prepaid burials or any other exempt asset on long lists provided by financial advisors and available online. A/Rs are not required to prove or document that they have spent down their wealth for medical or LTC expenses. Purchasing exempt assets in order to spend down artificially to Medicaid's asset eligibility limit may cost the program upwards of $100 billion or more for each generation of recipients.[20]

Even the wealthy qualify for Medicaid LTC benefits using special annuities, trusts and sophisticated asset management strategies. But why would financially comfortable people choose Medicaid with its reputation for sub-standard care when they could have commanded access to the best care as private payers? Affluent people hold back "key money" from the artificial asset spend-down process so they can gain access to the better Medicaid nursing homes and other LTC providers that have relatively few Medicaid slots and are desperate to attract private payers who generate higher revenue than Medicaid. This is the root and cause of the disparities in care access and quality affecting socio-economically disadvantaged people that have come to be called "structural LTC racism."

Medicaid benefits the capable to the detriment of the vulnerable in other ways as well. Its "current financing structure discriminates against the more vulnerable Medicaid enrollees in favor of the able-bodied, working-age, generally childless adults or Affordable Care Act (ACA) expansion enrollees."[21] The Federal Medical Assistance Percentage (FMAP) that determines the federal contribution to Medicaid expenditures is biased in favor of wealthy states instead of favoring states with higher numbers of poor people as originally intended.[22]

d. **Proposal**: The SSA legislation authorizing Medicaid contained no requirement that people become "destitute" or "impoverished" to qualify. Yet that is the common picture of Medicaid LTC eligibility presented in both the popular and academic media. If it were true, most of the problems with Medicaid-financed LTC recounted above would disappear. Most people would plan ahead to pay privately for LTC if needed. Few would remain dependent on public assistance. Medicaid could afford to

pay market rates eliminating the caregiver shortage, ending discrimination against Medicaid recipients, and funding HCBS for all who need and want them.

Therefore, **Medicaid should employ much stricter financial eligibility criteria**. Eliminate all Medicaid financial eligibility rules that disfavor the poor and favor the affluent. Require proof that resources are spent down on qualified medical or LTC costs as is required for income spend down. End the practice of purchasing exempt assets to self-impoverish artificially. Terminate most resource exemptions. Change the home equity exemption to require the use of home equity conversion, such as reverse mortgages, to extract income to be used to pay privately for LTC until equity is exhausted. Disallow trusts, annuities and other methods of Medicaid planning. In these ways, minimize the number of people needing Medicaid, prioritize socioeconomically marginalized groups, and incentivize early LTC planning through savings, investment or insurance to avoid Medicaid dependency. For ideas on how to invigorate early LTC planning and identify private economic resources enabling people to pay privately for LTC, see the section on "LTC Choices" in "Long-Term Care: The Solution."

e. **Petition**: Critics will excoriate this solution as cruel and uncaring. But ironically, it is no different than the way Medicaid's current LTC financial eligibility system is routinely described in the popular and academic media. Examples include the KFF and *New York Times* "Dying Broke" series and this *Health Affairs* article "How States Can Support Individuals In The Long-Term Services and Supports Gap" describing a "forgotten middle" with no access to Medicaid that does not exist. [23] This "Medicaid requires impoverishment" hoax that few challenge overloaded Medicaid with too many enrollees and created a moral hazard. Consumers could, should and would have prepared and paid privately in the absence of Medicaid's covering catastrophic care late in life while preserving wealth. This proposal replaces perverse public policy incentives that discourage personal responsibility and planning with positive motivation that will lead to better access and higher quality care for all. Residual Medicaid dependents will get much better care as the program becomes able to pay private market rates for fewer dependents.

(3) Coverage

a. **Principle**: **Cover the LTC people prefer**.

b. **Options**: Medicaid paid exclusively for nursing home care until very limited home and community based services (HCBS) became available through highly restrictive state plan waivers in 1981. HCBS prevail now in case numbers and spending though waiting lists obstruct access and total spending, including institutional care, continues to rise contradicting hopes that home care would reduce overall costs.

c. **Policies**: Medicaid's exclusive payment for nursing home care from 1965 until 1981 impeded the development and growth of HCBS alternatives in the private market. Free or subsidized institutional care provided through public assistance crowded out

the development and growth of care alternatives most consumers prefer. Assisted living and home care only evolved as major private-pay options after Medicaid-financed nursing home care developed an extremely poor reputation. Medicaid attempted to respond to consumer preferences by providing waivered HCBS but to control costs this option was limited to enrollees who already had a nursing home level of medical need and waivered HCBS were not allowed to exceed in total what institutional care alone would have cost. Consequently, to this day 710,000 Medicaid enrollees remain on HCBS waiting lists all across the country. Millions more people rely on unpaid care provided by friends and families who despair of placing loved ones in welfare-financed nursing homes. After decades of rebalancing from institutional to home care, HCBS now prevails but a key lesson learned is that the transition did not save money. Total costs continue to rise annually. It turns out many people who need and receive Medicaid home care end up needing institutional care eventually anyway.

d. **Proposal**: **Let Medicaid patients choose their kind and venue of care** with advice of medical professionals, geriatricians and gerontologists. Currently only private payers have the freedom to choose how and where they receive LTC. Medicaid enrollees are restricted to whatever options their state program funds and provides. These benefits vary widely across states and eligibility groups creating wide disparities.[24] When Medicaid pays market rates, program recipients will have access to the same types and venues of care as private payers.

e. **Petition**: Likely opposition to this proposal is that it would be unaffordable. Of course that is true given how Medicaid operates now as the dominant LTC payer in the United States. But with the changes proposed above enacted, most people would pay for LTC privately. That would infuse the LTC market tremendously with desperately needed private financing. Home care agencies, assisted living facilities and nursing homes would thrive on the investment of private revenue and capital. With only a much smaller number of people dependent on Medicaid, the program could afford to pay market rates for all levels of care eliminating the need to depend on the public's aversion to nursing homes as a means of controlling expenditures.

(4) **Quality**

a. **Principle**: **Provide high quality care for all**.

b. **Options**: Medicaid could have prioritized quality care. Policy makers chose instead to reduce program expenditures. This tradeoff between quality and cost continues to plague the program.

c. **Policies**: By paying less than market rates for care, Medicaid impaired providers' ability to hire, compensate, and retain staff, maintain facilities, and ensure quality. Low Medicaid reimbursements made Medicaid patients into second-class consumers. Because Medicaid pays only two-thirds of the private rate, LTC providers prefer and favor private payers. People with sheltered wealth who are about to qualify for

Medicaid gain special preference by holding back "key money" to pay privately for a while. That makes them highly attractive to providers. The poor and disadvantaged are quickly crushed by private LTC expenditures and have access only to the lower quality providers that are more heavily reliant on Medicaid. Ironically, once eligible for Medicaid, recipients are required to contribute nearly all of their private income to offset the cost of their care, but LTC providers do not receive this funding at private pay rates. Medicaid accepts the private funds, but only compensates providers with the difference up to the meager Medicaid reimbursement rate.

d. **Proposal**: **Eliminate the reimbursement differential between Medicaid and private pay** as proposed above in order to remove the quality disparity and end the discrimination against Medicaid enrollees. Key money will no longer buy special treatment when Medicaid pays market rates. This will end the pernicious problem of structural LTC racism.

e. **Petition**: The earlier objection that Medicaid cannot afford to pay market rates and our response that it will be able to do so after financial eligibility rules change apply here also. Everything turns on Medicaid no longer subsidizing consumers' denial of LTC risk and cost by paying for catastrophic care costs late in life *and* protecting sheltered or divested wealth as now. End that moral hazard and the LTC marketplace will self-correct based on consumers' self-interest to prepare for LTC risk and cost.

(5) **Regulation**

a. **Principle**: **Minimize regulation consistent with safety**.

b. **Options**: Having opted for Medicaid not to pay enough to ensure quality care, policymakers sought to achieve at least minimally adequate care through regulation. The results have been poor.

c. **Policies**: From the beginning Medicaid struggled to achieve quality while constraining program expenditures. To do that, regulations, controls and inspections proliferated. By 1987 quality under Medicaid had deteriorated so far and publicity was so bad that Congress and President Reagan acted. The Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act (OBRA) of that year, changed the focus of regulation, established new standards, and revamped the inspection and enforcement process. But twenty years later, scholars concluded that "Although there was an initial upgrading of the quality of care as a result of OBRA 87, improvements appear to have reached a plateau."[25] Fifteen years after that assessment Medicaid-dominated nursing home care still attracted severe criticism in a 2022 National Academies study titled The National Imperative to Improve Nursing Home Quality.

d. **Proposal**: **End the need for excessive regulation by empowering quality through market reimbursement rates**. Heavy regulation to counteract the consequences of poor Medicaid reimbursement did not and will not work. When Medicaid pays market rates for fewer enrollees and most people are prepared to pay privately and

avoid Medicaid, market competition will ensure better quality than ham-handed government regulation ever has. In a free market, unhappy customers vote with their feet. They find the best providers. The best providers prosper. Others disappear. Open competition fosters creativity and entrepreneurship. New methods and venues of care can evolve if unsuppressed by free, subsidized, underfunded Medicaid services crowding them out.

a. **Petition**: This proposal to substitute competition for regulation will evoke a knee jerk reaction. "Greedy LTC providers put profits ahead of care," critics will say. But that is not how free markets work. Companies compete to provide maximum quality at the lowest possible price in order to gain and increase their market share and profits. By overcoming the reflexive opposition to capitalism and free markets, the provision and financing of LTC can be revolutionalized and freed from damaging government domination.

(6) Demographics

a. **Principle**: **Prioritize aging and disability**.

b. **Options**: Although aged and disabled people account disproportionately for Medicaid's medical and LTC expenditures, most media and public policy attention focuses on younger, healthier enrollees.

c. **Policies**: Aged or disabled recipients, the heaviest users of LTC, are 23 percent of Medicaid enrollees but they account for 51 percent of program spending.[26] Six percent of Medicaid recipients use LTC, but they account for 34 percent of expenditures.[27] LTC users' Medicaid spending is eight times higher than for non-users.[28] Despite these imbalances, LTC for the aged and disabled does not receive the policy priority it should. Medicaid LTC faces low funding, limited access, questionable quality, insufficient workforce, and little political priority. Instead of addressing these problems, most attention goes to the young, who cost much less. The Affordable Care Act even "created a new eligibility category for Medicaid—able-bodied, working-age adults—with a much higher federal reimbursement percentage for these enrollees."[29] The most common proposals to improve LTC call for more government money and regulation, especially implementation of a new compulsory, payroll-funded, entitlement program on the model of Social Security and Medicare. Although repeatedly proposed and rejected, this LTC-for-all model continues to crowd out serious consideration of private market solutions on which most analysts have given up. But something has to be done. Exploding Medicaid LTC costs threaten to crowd out other state and federal spending priorities that receive more media and public policy attention.

d. **Proposal**: **The proposals made above and summarized in the table below will reprioritize LTC for the aged and disabled**. When Medicaid pays market rates for only the neediest Americans and in the kind and venue of care they prefer, access and quality will soar with far less regulation than now. After Medicaid is no longer a

primary payer for people with sheltered income and assets who have failed to save, invest or insure for LTC, private payers at market rates will predominate in the LTC marketplace enabling Medicaid to provide the same services and payments as private payers expect and to receive commensurate care access and quality.

e. **Petition**: Closed minded assumptions that only government can solve problems will likely assail this proposal too. Proponents should point out how poorly the current LTC services and financing system has done so far. If we stop doing what we have always done we can achieve different and better results.

Summary Table

Policy Area	Principle	Current Policy	Result	Proposal
1 Payment	Pay market rate	Medicaid pays below market rates	Poor access/quality; staff shortages	Medicaid pays what A/R can't of market rate
2 Eligibility	Neediest only	No hard $ caps on income or assets	Medicaid planning; favors affluent; disfavors poor	$ caps; no exempt assets; prove spend down for care
3 Coverage	Cover care continuum	Institutional bias, then rebalancing	Costs up; providers only offer care Medicaid funds	Pay market rates for care across continuum
4 Quality	High for all	Low reimburse-ment causes low quality	Providers compete for private payers giving advantage to affluent with key money	Market rates mean rich and poor get same treatment
5 Regulation	Minimal for safety	Heavy to correct for poor quality caused by low reimbursements	No regulation is enough; excessive now, e.g. CMS's staffing mandate	Reduce regulation with competition at market rates
6 Demographics	Prioritize aging and disability	Favor young and (lately) able-bodied	Old and disabled dependent on public assistance	Empower private payers to reach aged/disabled
Policy Area	**Principle**	**Current Policy**	**Result**	**Proposal**

[1] Kirsten J. Colello, "Who Pays for Long-Term Services and Supports?," Congressional Research Service, updated September 19, 2023.
[2] Inferred from Helen C. Lazenby and Suzanne W. Letsch. 1990. "National Health Expenditures, 1989," *Health Care Financing Review*. 12 (2) and Nelda McCall editor. 2001. *Who Will Pay for Long Term Care? Insights from the Partnership Programs*. Chicago, Illinois. Health Administration Press.
[3] "Medicaid's inflation-adjusted LTC expenditure projections reported above increase at an average annual rate of just under 3 percent per year from $130 billion in 2020 (0.62 percent of GDP) to $179 billion by 2030 (0.71 percent of GDP). As population aging progresses after 2030, Medicaid's inflation-adjusted LTC expenditures are projected to grow even faster – at about 5 percent per year – reaching $466 billion by 2050 (1.25 percent of GDP)." Blog post, "Projecting Medicaid's Long Term Care Expenditures," March 9, 2022, Penn Wharton Budget Model.
[4] "One in twenty of all people in the U.S. is projected to be 85 or older by 2060, a group that is likely to have the highest rates of LTSS needs and utilization as a quarter of them are frail." Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports (LTSS)," KFF, July 8, 2024.
[5] Alice Burns, Abby Wolk, Molly O'Malley Watts, Maiss Mohamed, and Maria T. Peña, "A Look at Waiting Lists for Medicaid Home- and Community-Based Services from 2016 to 2024," KFF, October 31, 2024.
[6] Jackson Hammond, "Paragon Prognosis: Nursing Bad Policy," Paragon Health Institute, May 13, 2024.
[7] Charlene Harrington, Joshua M. Wiener, Leslie Ross, and MaryBeth Musumeci, "Key Issues in Long-Term Services and Supports Quality," KFF, October 27, 2017.

[8] Liz Liberman, "Medicaid Reimbursement Rates Draw Attention," *NIC/CARES blog*, 2018.
[9] Elder Law Answers. "Nursing Home Discrimination Against Medicaid Recipients." Created date: 07/27/2016; accessed November 30, 2024.
[10] "Each year, older Americans who need long-term services and supports (LTSS) receive unpaid assistance with personal care from millions of helpers. Far more older people with care needs receive unpaid care than paid care." Melissa M. Favreault, Richard W. Johnson, Judith Dey, William Marton, Helen Lamont, and Lauren Anderson, "The Economic Value of Unpaid Care Provided to Older Adults Who Need Long-Term Services and Supports," Issue Brief, Washington (DC): Office of the Assistant Secretary for Planning and Evaluation (ASPE); 2023 August 2.
[11] Sec. 1901. [42 U.S.C. 1396]: For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.
[12] Robert J. Buchanan, R. Peter Madel, and Dan Persons, "Medicaid payment policies for nursing home care: A national survey," *Health Care Financing Review*, Fall 1991, Vol. 13, No. 1, p. 55.
[13] Ibid.
[14] Ibid.
[15] Joshua M. Wiener and David G. Stevenson, "Repeal of the 'Boren Amendment': Implications for Quality of Care in Nursing Homes," Urban Institute, Series A, No. A-30, December 1998.
[16] Brian Blase, "The Danger of Price Controls," Paragon Health Institute, August 21, 2024.
[17] "The chronic care nursing home market has two primary payer types: Medicaid and private-pay. … The Medicaid rate is, on average, about 70 percent of the private-pay price." David C Grabowski and Joseph J Angelelli, "The Relationship of Medicaid Payment Rates, Bed Constraint Policies, and Risk-Adjusted Pressure Ulcers," *Health Services Research*, 2004 Aug;39(4 Pt 1):793–812.
[18] Other states capped income but allowed applicants to divert extra income into special trusts achieving the same goal of qualifying despite high incomes.
[19] Countable assets are cash, stocks, bonds. Basically, anything easily convertible to cash.
[20] Paragon Prognosis: Medicaid's $100+ Billion Leak
[21] Brian Blasé and Drew Gonshorowski, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States," Paragon Health Institute, July 2024.
[22] Ibid.
[23] Laura Benzing, Hannah Godlove, and Megan R. Burke, "How States Can Support Individuals In The Long-Term Services and Supports Gap," *Health Affairs*, July 24, 2024. *Health Affairs* published my comment refuting this article immediately after it online. See also LTC Bullet--There Is No "LTSS Gap."
[24] Rhiannon Euhus and Priya Chidambaram, "A Look at Variation in Medicaid Spending Per Enrollee by Group and Across States," KFF, August 16, 2024.
[25] Joshua Wiener, Marc Freiman, and David Brown, "Nursing Home Quality Twenty Years After the Omnibus Budget Reconciliation Act of 1987," *Kaiser Family Foundation*, 2007.
[26] Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports (LTSS)," KFF, July 8, 2024.
[27] Robin Rudowitz, Jennifer Tolbert, Alice Burns, Elizabeth Hinton, and Anna Mudumala, "Medicaid 101," KFF, May 28, 2024.
[28] Priya Chidambaram and Alice Burns, "10 Things About Long-Term Services and Supports (LTSS)," KFF, July 8, 2024.
[29] Brian Blase, "Medicaid Financing Reform: Stopping Discrimination Against the Most Vulnerable and Reducing Bias Favoring Wealthy States," Paragon Health Institute, July 24, 2024.