



***The
Heartland Model
for
Long-Term Care
Reform***

A Case Study in Nebraska

Presented by the



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

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Center for Long-Term Care Financing

“Dedicated to ensuring quality long-term care for all Americans”

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Executive Summary

"One can go into a wild country and make it tame, but, like a coat and cap and mittens that he can never take off, he must always carry the look of the land as it was."

Big Andrew in Mari Sandoz' "Old Jules"

This quote from a classic novel of the state's pioneer days suggests "you can take the people out of Nebraska, but you can't take Nebraska out of the people."

The best hope Nebraska and America have to reform long-term care is to revitalize the spirit of personal responsibility and self-sufficiency characterized by the plains' pioneers.

It's not too late, but nearly forty years of publicly financed long-term care have created a strong and growing sense of entitlement to Medicaid benefits among Nebraskans.

Nebraska Medicaid spent \$372 million on long-term care in 2003 and the program continues to grow at nearly seven percent a year, triple the national inflation rate.

Nevertheless, long-term care providers complain that Medicaid reimbursement rates are too low to ensure adequate staffing and quality care. They fear anticipated future cuts will be devastating and cause bankruptcies and closures.

Medicaid pays for 54.4 percent of all nursing home patient days in Nebraska. The state could save \$54 million per year by dropping this percentage to 44.4 percent.

Conversely, if the percentage of nursing home days paid by Medicaid continues to increase to 64.4 percent, expenditures will increase by \$54 million per year.

The state Medicaid program has made long-term care benefits more attractive by reducing nursing home institutionalization and increasing home and community-based care for program recipients.

Despite recommendations in Nebraska's 1997 Long-Term Care Plan, however, the state has done little to control Medicaid eligibility growth or to encourage private financing options.

Too few Nebraskans prepare for the risk and cost of long-term care by purchasing private insurance and fewer still tap the equity in their homes by means of reverse mortgages.

Most older Nebraskans pass their wealth--such as homes, farms, ranches and businesses--to the younger generation in their late 60s or early 70s which results in quicker Medicaid long-term care eligibility whether the transfers were done for that purpose or not.

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Medicaid eligibility workers estimate conservatively that 20 percent of long-term care cases transfer assets without penalty which would result in a loss of \$49 million across the caseload that might otherwise have been spent privately for care.

Huge amounts of wealth are sheltered from long-term care spend-down requirements by federally mandated exemptions such as prepaid burials for Medicaid recipients and their spouses, which may divert over \$51 million from private long-term care spending.

Nebraska Medicaid exempts the first \$5,000 of a deceased Medicaid long-term care recipient's estate from otherwise mandatory "estate recovery" if a child of any age survives the recipient.

At any given time, upwards of \$31 million is exempted from estate recovery in this way. By eliminating the exemption, Nebraska could recover an additional \$10 million per year, after expenses, from estates.

Bottom line, people aware of long-term care have come to see Medicaid as an entitlement that should ensure access to care and insure an inheritance for their heirs. People unaware of long-term care remain so because Medicaid does pay for most such care.

Fiscal reality is closing like a vise on this "entitlement mentality." Nebraska should take steps soon to underscore that Medicaid is a means-tested public assistance program, i.e. welfare, and that citizens are personally responsible to pay for their own long-term care.

The following proposed corrective actions are described in greater detail in the section of this report titled "Analysis and Recommendations."

Tighten Medicaid long-term care eligibility rules and strengthen Medicaid estate recoveries in order to divert more people to private long-term care financing alternatives and reduce program expenditures.

Use some of the savings from these initiatives to fund an educational campaign to wake up the public to the risk of long-term care and the importance of planning early to pay privately if and when extended care becomes necessary.

Use some of the savings to finance state tax incentives for the purchase of private long-term care insurance and the use of home equity conversion to pay for long-term care and delay or prevent Medicaid eligibility.

Discourage financial abuse of the elderly and reduce program expenditures by actively prosecuting cases where seniors have been left impoverished and dependent on Medicaid because of financial expropriation by relatives or others.

Attack the entitlement mentality and encourage personal responsibility with a "sense of the legislature" resolution like the "Heartland Manifesto" proposed on page 31.

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Preface

This report recounts the findings and recommendations of a project conducted by the Center for Long-Term Care Financing. The project--titled "Controlling Medicaid Long-Term Care Costs"--was funded under contract with the Nebraska Legislature. The contract, including a detailed description of the project, is included in this report as Appendix C.

The Center for Long-Term Care Financing is a 501(c)(3) charitable, nonprofit, nonpartisan think tank and public policy organization founded in 1998. The Center's mission is to ensure access to quality long-term care for all Americans. In addition to providing technical assistance to state Medicaid programs, the Center for Long-Term Care Financing publishes several online newsletters and maintains a website with extensive information on long-term care financing at <http://www.centerltc.org/>.

The project director and author of this report, Stephen A. Moses, is President of the Center for Long-Term Care Financing. He writes, speaks, testifies and consults widely on the subjects of Medicaid nursing home eligibility, Medicaid estate planning, liens, estate recoveries, and on public/private long-term care financing partnerships. He was previously a Medicaid State Representative (nine years) for the federal Health Care Financing Administration (HCFA) and Senior Analyst (two years) for the Office of Inspector General of the U.S. Department of Health and Human Services (IG). He directed and authored three national studies for HCFA and the IG on Medicaid estate planning.

Amy Marohn-McDougall, Executive Director of the Center for Long-Term Care Financing and Damon V. Moses, Administrative Coordinator participated actively in the collection and preparation of data for this report. They compiled and edited a 50-page document that provides answers from responding states to the national survey questionnaire designed and distributed for this project. See the "Survey Says" section of this report for a description and summary of the findings and http://www.centerltc.org/survey_responses.pdf for a full compilation of states' responses.

Staff of the Nebraska Legislature's Health and Human Services Committee assisted the project by facilitating access to private long-term care experts, legislators, public and private senior advocates, elder law attorneys, long-term care provider associations, key state administrative staff, and essential legal, regulatory and administrative documents. Committee staff also arranged conference space, local telephone service, and photo-copy support. We wish to express our thanks and appreciation especially to the Committee's Legal Counsel Jeff Santema and to Committee Clerk Joan Warner, both of whom provided exceptional support and assistance for this project.

Liz Hruska of the Nebraska Legislative Fiscal Office provided invaluable technical assistance and advice. She attended all of the project briefings and interviews and frequently offered extremely helpful background, elucidation, and context.

The purpose of this report is to analyze the long-term care financing problem in Nebraska and to propose a variety of measures to contain the state's Medicaid long-term care expenditures while

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improving access to and quality of care for all citizens. The report identifies the chief problems with respect to costs and explains why they persist. It provides alternative solutions that can be utilized under the existing Medicaid structure or, alternatively, by means of federal waivers.

In pursuit of this objective, the contractor (the Center for Long-Term Care Financing in the person of Stephen Moses) visited Nebraska during the weeks of October 13-17 and October 27-31, 2003 and conducted a series of interviews and discussions. Specifically, he met with long-term care policy makers and stakeholders including representatives of the Medicaid program, members of the state legislature, health care providers, senior advocates and others. A complete list of respondents and interviewees for the project is provided in Appendix B.

Each group of respondents received a packet of background information on the project. A brief presentation introduced all study participants to a distinctive approach to analyzing the long-term care financing system. Finally, each interviewee was asked to respond to a long list of questions in a prepared interview schedule. We would like to express our appreciation to each one of the 101 respondents and interviewees who provided the information on which this report is based.

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The Big Picture: Long-Term Care Service Delivery and Financing in the United States

America's long-term care system is already in serious trouble. A brief summary of the national problems with long-term care service delivery and financing will set the stage for comparative analysis of the challenges Nebraska faces. This is an important first step for this report because Nebraska is arguably well-positioned to serve as a model for national long-term care financing reform.

- Nursing homes face severe financial challenges throughout the United States. A spate of bankruptcies in the late 1990s and early 2000s decimated many of the industry's largest nursing facility companies. At one point, 22 percent of U.S. nursing home beds were in bankrupt facilities.
- Assisted living facilities, which offer an attractive new service delivery modality for the aging, have filled too slowly to be profitable in many parts of the country. Their cost (upwards of \$30,000 per year on average) and the fact that 90 percent of their business is private-pay puts them financially beyond the reach of many Americans.
- Home health agencies and companies have suffered a fate similar to nursing homes with hundreds of recent bankruptcies. Changes in Medicare reimbursement policies implemented in the Balanced Budget Act of 1997 (BBA '97) and ongoing shortfalls in Medicaid reimbursement exacerbated financial problems for home health providers, as they did for the institutional providers.
- Because of the long-term care providers' financial struggles and low profitability, debt and equity capital to build, operate, and maintain extended care facilities have become severely limited. Once excited by the industry's potential based on seemingly promising aging demographics, Wall Street investors have largely abandoned long-term care.
- Medicaid and Medicare, which pay for the vast majority of all professional home health and nursing facility services in the United States, have become notoriously expensive. Policy makers anguish over how to control the growth of expenditures in these programs without increasing taxes or reducing services, a seemingly hopeless dilemma.
- Despite the high risk and enormous cost of long-term care, the public seems indifferent to the subject. Experts agree most people are in denial about long-term care. Less than 10 percent of seniors and very few members of the bulging baby-boom generation have purchased private insurance against this risk.

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- Most people only become aware of the high cost of long-term care when they find themselves in crisis, after being stricken by stroke, Parkinson's Disease or Alzheimer's, for example. At that stage, the infirm elder is often mentally incapacitated and the responsibility to find and finance professional long-term care falls to a spouse or adult child. Thousands of attorneys and other financial advisers across the country specialize in helping people qualify for Medicaid long-term care benefits by means of sophisticated techniques that artificially impoverish elders while protecting their wealth for heirs.
- Home equity of the elderly, a gigantic repository of wealth approaching \$1.8 trillion, goes largely untapped for long-term care. Reverse annuity mortgages and other forms of home equity conversion have been unpopular and little used. Few seniors employ these readily available financial tools to mine their illiquid home equity for supplemental income to purchase private long-term care services.
- Although most people prefer to receive care in their own homes rather than in nursing homes, America's long-term care system is heavily biased toward institutional, mostly nursing-home care. Our home and community-based services (HCBS) infrastructure is underdeveloped and underfinanced. National and state initiatives to retrofit a HCBS system by means of Medicaid waivers have shown disappointingly slow results.
- Notoriously low Medicaid nursing home reimbursement rates, often less than the cost of providing the care, have hampered facilities' ability to hire, train and retain quality caregiving staff. Nurses and nurse's aides are in very short and ever-declining supply. Low-wage workers can find more attractive, less demanding work in other businesses.
- Quality of care in America's long-term care facilities, especially nursing homes, has become a huge concern. Many seniors tell researchers they would rather die than go to live permanently in a nursing home. The relationship between quality problems and the system's heavy dependence on relatively low reimbursements from government programs is a subject of constant analysis and discussion.
- Long-term care quality problems have led to burgeoning growth in tort liability lawsuits against nursing homes and assisted living facilities. In some states, lawyers advertise on television or highway billboards for clients dissatisfied with their, or their parents', long-term care.
- Huge jury settlements against long-term care providers have driven many of them to (or over) the brink of bankruptcy. Liability insurance premiums have skyrocketed to the point where many nursing homes and assisted living facilities can no longer afford coverage. A recent nursing home fire in Tennessee killed 16 residents in a facility that had dropped its liability insurance coverage.

The dismal current condition of America's long-term care service delivery and financing system is especially worrisome when viewed in the context of aging demographics. The well-known "Age Wave" has not yet begun to crest, much less crash. The solvency of Social Security and

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Medicare are already grave concerns, but long-term care for the baby boom generation remains the pre-eminent, though still largely ignored, social challenge looming in the future.

By Comparison: Long-Term Care in Nebraska

On the Plus Side

In many ways, Nebraska's long-term care service delivery and financing system is in better condition than the system that prevails throughout much of the rest of the country. For this reason, Nebraska (and other states in the Heartland) may point the way toward a national long-term care solution. For example:

- Nebraska has the lowest Medicaid nursing home census in the United States. As of 2002, Medicaid covered only 52.8 percent of nursing home residents in Nebraska, as compared to an average of 66.7 percent for the country as a whole.¹ This is important because higher dependency on relatively low Medicaid reimbursements for nursing home care can exacerbate financial, staffing and quality problems.
- Nebraska has one of the highest market penetrations for private long-term care insurance in the country--over 15 percent. Other states in the Heartland have similarly high rates of long-term care insurance² and concomitantly high private-pay nursing home censuses.³ This is important because people who pay privately for nursing home care often pay half again as much as the Medicaid reimbursement rate.⁴
- Despite the discrepancy between Medicaid reimbursement rates and private pay rates in much of the rest of the country, Medicaid staff and some providers report that Medicaid rates--at least until recently--have been comparable in Nebraska to private pay rates and have sometimes even exceeded private pay rates.
- Nebraska has made great strides in the last few years toward deinstitutionalizing Medicaid long-term care recipients and providing them alternative care in the community. State staff report that average monthly nursing facility recipients dropped from 8,743 in 1996 to 7,872 in 2003. In the same period, Nebraska's home and community based waiver (home care and assisted living) slots increased from 600 to 4,200.

¹ C. McKeen Cowles, *Nursing Home Statistical Yearbook, 2002*, Cowles Research Group, Montgomery Village, Maryland, 2003, p. 64.

² Susan A. Coronel, *Long-Term Care Insurance in 2000-2001*, Health Insurance Association of America, Washington, DC, 2003, p. 22. "HIAA found that Arizona, Colorado, Illinois, Indiana, Iowa, Kansas, Maine, Minnesota, Missouri, Montana, NEBRASKA, North Dakota, South Dakota and Washington had the highest market penetration rates." (p. 22, emphasis added).

³ C. McKeen Cowles, *Nursing Home Statistical Yearbook, 2002*, Cowles Research Group, Montgomery Village, Maryland, 2003, p. 64.

⁴ Steven R. Gregory and Mary Jo Gibson, *Across the States, 2002 Profiles of Long-Term Care, Nebraska*, AARP Public Policy Institute, Washington, DC, 2002, http://research.aarp.org/health/d17794_2002_ats_ne.pdf. According to AARP, the national average Medicaid reimbursement per day for nursing facility care in 1998 was \$96 as compared to the national average private pay rate per day, 2001 of \$150. For comparable years, the Medicaid rate is usually reported as approximately 70 percent of the private pay rate.

- Nearly everyone interviewed for this project indicated that quality of care in Nebraska's nursing homes and assisted living facilities is very good and that there is little or no discrepancy between the quality of care received by Medicaid recipients as compared to private-payers.
- More Nebraskan seniors own their homes on average (80.8 percent) than is true for the country as a whole (79.4 percent). The state ranks 22 in the nation for home ownership by the elderly. This is important because home value represents the single biggest asset most seniors possess. Home equity can ensure access to quality long-term care in the private marketplace for seniors who might not otherwise be able to afford care or private insurance.⁵
- Tort liability suits against long-term care facilities in Nebraska have been few and relatively small. Comparatively low Medicaid census, relatively high Medicaid reimbursement rates, and the fact that Nebraska does not allow punitive damages may account for the dearth of liability suits and for the fact that those which do arise are quickly settled by insurance companies.
- Finally, many interviewees for this study commented on the pioneer spirit of self-reliance and personal responsibility that remains strong in Nebraska. The opinion was nearly unanimous that Medicaid should be a safety net for people in need and not a universal benefit available to anyone who can manipulate the eligibility rules. Such traditional Heartland values underpin Nebraska's generous, but limited public long-term care system.

On the Minus Side

Nevertheless, Nebraska does face many of the same demographic and long-term care challenges that afflict the rest of the country. The state, like the country as a whole, needs to act soon to resolve growing problems and to mitigate future threats. For example:

- The percent of persons age 65 and older who reside in nursing facilities averaged 4.2 percent in the U.S. as a whole in 2001. The comparable figure for Nebraska is 6.5 percent. "In 17 states, nursing home residents were less than four percent of the population age 65 and older, with six states, Florida, Oregon, Hawaii, Arizona, Nevada, and Alaska below three percent." Nebraska ranks number two in the country for percent of people age 65 plus in nursing facilities.⁶
- The share of persons age 85 and older, the age group most likely to need long-term care, will rise from 1.5 percent to 1.9 percent between 2000 and 2020 in the United States. The comparable increase in Nebraska is from 2.0 percent to 2.7 percent.⁷ Nebraska must

⁵ *Ibid.*

⁶ *Ibid.*

⁷ Alzheimer's Disease is the single biggest medical cause requiring expensive long-term care. Nearly half of all people over age 85 nationally already have Alzheimer's. "One of the most notable recent developments in Nebraska's vital statistics has been the entry of Alzheimer's Disease into the top ten causes of death, which occurred

cope with nearly half again as many "old-old" (over age 85) residents *per capita* in the future as compared to the rest of the country.⁸

- Medicaid long-term expenditures have increased in Nebraska from \$223.5 million in Fiscal Year 1996 to \$371.9 million in Fiscal Year 2003. This rate of increase, approximately seven percent per year, is the same rate reported in a 1997 study of long-term care in Nebraska for the four years previous to Fiscal Year 1997. Hopes to reduce the rate of growth in long-term care expenditures have so far been unrealized.⁹
- Although nursing home and assisted living financial difficulties have not been as big a problem in Nebraska as in other parts of the country, some long-term care providers predict that bankruptcies will soon begin to occur due to recent changes in the Medicaid reimbursement system. Pat Snyder, Executive Director of the Nebraska Health Care Association and the Nebraska Assisted Living Association, stated that her facilities are "no longer \$6.00 per day under funded by Medicaid, but it is \$9.43 per day now, and it's looking like \$13.30 based on simulated projections for 2003, and \$18.49 under funding per patient day for 2004."¹⁰
- Shortages of nurses and nurses aides to provide long-term care, especially in home and community-based settings in rural areas, are becoming a bigger and bigger problem in Nebraska. Long-term care providers, including home health agencies, assisted living facilities and nursing homes, find it increasingly difficult to compete, especially for low-wage workers, with other businesses and industries.
- Although Nebraska had the lowest Medicaid nursing home census in the country as of 2002, the percentage of nursing home residents in the state dependent on Medicaid seems to be creeping up. As of November 2003, 54.4 percent of nursing facility patient days were paid by Medicaid. This trend is very important to watch and control. An increase of ten percent in the proportion of nursing facility patient days paid by Medicaid from 54.4 percent to 64.4 percent would add approximately \$54,000,000 to Medicaid expenditures.¹¹

for the first time in 1995. The number of Nebraska deaths attributed to Alzheimer's Disease increased again in 2002, to 462, making it again the state's sixth leading cause of death. However, among women 75 and older, Alzheimer's Disease was the state's fourth leading cause of death in 2002." Source: <http://www.hhs.state.ne.us/ced/death02.pdf>.

⁸ *Ibid.*

⁹ Current data were provided by state staff, compiled by Liz Hruska of the Legislative Fiscal Office, and provided to Center for Long-Term Care Financing staff in an email November 10, 2003. Historical data are from "Nebraska's Long-Term Care Plan: Putting the Needs of Nebraskans First," Nebraska Health and Human Services System, May 1997, Executive Summary, no page number.

¹⁰ Source: Meeting and interview with proprietary long-term care providers on October 31, 2003. Ms. Snyder also said "Medicaid reimbursement is so inadequate it is affecting quality and may cause closures." She said that if the Boren Amendment--a 1980 federal law requiring adequate Medicaid reimbursement for nursing homes--had not been repealed, "we would have filed three lawsuits by now. These problems started when Boren went away. The situation has gotten worse in last five or six years. As the state has slipped into more and more fiscal problems, we've seen further deterioration of reimbursement."

¹¹ Source: Personal communication, email November 7, 2003, from Emi Nyman Giles, Program Analyst, Lead, Health and Human Services System, Finance & Support, Financial Services, Financial and Program Analysis.

- Although Nebraska's long-term care insurance market penetration rate is one of the highest in the country, local experts said that sales of this product are currently flat, that less than five percent of life and health agents in Nebraska market long-term care insurance, and that only one or two percent of agents specialize in this complicated policy.¹² Many interviewees who were experts in other aspects of long-term care, but laymen with regard to long-term care insurance, expressed doubts and criticism about the product. A few expressed praise and confidence in it. In general, the level of skepticism articulated about the value of private long-term care insurance was inversely proportional to the level of knowledge and personal experience of the interviewees with the product.
- Although Nebraska's home ownership rate among seniors is relatively high (80.8 percent), reverse annuity mortgage lenders in the state indicate that the market for home equity conversion is largely undeveloped.¹³ Suitably marketed, reverse mortgages can provide a godsend of supplemental income to help the aging maintain their accustomed lifestyle in the face of interest rates that have plummeted. Such extra income can also make private long-term care insurance premiums more affordable for low-income seniors or empower them to purchase private long-term care services which may help them remain in their homes and off Medicaid. Most interviewees for this study had negative opinions about reverse mortgage loans although few were knowledgeable about the product.¹⁴
- Although Medicaid estate planning--artificial self-improvement to qualify for Medicaid long-term care benefits--is not nearly as prevalent in Nebraska as in many other states, there is evidence that the practice is increasing, based on comments from numerous interviewees. More importantly, however, we learned that large amounts of wealth are passed from older to younger generations in Nebraska for reasons other than (or in addition to) qualifying for Medicaid. Such transfers of homes, businesses, farms and ranches--done in the normal course of estate planning¹⁵--have the (perhaps) unintentional but nevertheless devastating effect of drastically reducing the assets of future long-term care patients that might otherwise have been spent down privately prior to qualification for Medicaid long-term care benefits. The faster people spend down to Medicaid asset levels, the sooner they become dependents of the state and the greater the cost of the program.
- Although Nebraska's Medicaid program has creatively increased cost-effective home and community-based alternatives to expensive nursing home institutionalization, the state has already de-institutionalized most of the lowest acuity nursing home patients. Further

¹² Source: Meeting and interview with long-term care insurance specialists on October 13, 2003. A meeting and interview with representatives of the State Department of Insurance on October 16, 2003 produced similar estimates.

¹³ Source: Meeting and interview with home equity conversion lenders on October 15, 2003.

¹⁴ Home equity is already at risk for long-term care in Nebraska. The state requires Medicaid recipients to sell their homes after a grace period if they are unable medically to return and if no exempt relative continues to reside in the home. A question was raised during this study as to whether or not Nebraska is in compliance with federal law and regulations with regard to this requirement. Whatever the resolution of that question, it does appear that much home equity has already been transferred out of the ownership of Nebraskan seniors by the time they apply for Medicaid, as explained in the next paragraph.

¹⁵ Interviewees opined that such transfers are done primarily to avoid probate and/or inheritance taxes.

relocation of Medicaid recipients into the community will be ever more difficult because those remaining in nursing facilities are the most frail or infirm. Another concern raised by the State Medicaid Director is the "woodwork factor," i.e. the tendency for added home care or assisted living slots to be quickly filled by persons in the community who were previously managing somehow without state support. Ironically, the more attractive Nebraska makes Medicaid long-term care services by providing services in the home and community, the less likely Nebraskans will be to plan, save, invest or insure to be able to pay for their own long-term care and the more likely they will be to plan for Medicaid eligibility. Thus, controlling eligibility for Medicaid long-term care benefits is critical to the goal of improving the program's services without increasing costs.

- Although tort liability suits against long-term care facilities in Nebraska have not been as frequent or as devastating as in many other states, Nebraska and Nebraskans are still being affected by the problem. Liability insurance premiums are skyrocketing here just as they are elsewhere. Long-term care providers reported annual premium increases of several hundred percent. This is a good example of how deficiencies in the long-term care system elsewhere in the country can have a devastating impact at home. Only comprehensive long-term care reform can resolve such problems.
- Finally, although many of the interviewees for this study spoke proudly of Nebraskans' pioneer spirit of independence and self-sufficiency, just as many pointed out that the state and its citizens are already sliding down a slippery moral slope toward an "entitlement mentality." Over and over again, comments were made that more and more Nebraskans are coming to believe that because they paid their taxes, they have a right to receive government-financed long-term care and to pass an inheritance to their heirs. Such public sentiment is becoming an irresistible political force that will soon impact (if it has not already) the immovable economic object of fiscal reality.
- Nebraska has already increased certain taxes and cut some Medicaid benefits and educational programs to relieve the fiscal stress on state budgets. Nevertheless, "The State of Nebraska appears to be headed toward a fourth straight year of budget cuts. A state forecasting board slashed the state's revenue projection Friday [October 31, 2003] by \$198 million. Unless the economy picks up, that's the amount the state's budget must be cut, or the amount taxes must be raised, during the next session of the Legislature."¹⁶

The fiscal and long-term care crises facing the United States, the Heartland, and Nebraska can no longer be ignored or deferred. Clearly, something has to give. Difficult choices must be made, and soon. It behooves policy makers to make these difficult choices in the full knowledge of how and why the long-term care problems described above came to be.

¹⁶ Robynn Tysver, "Budget May Need More Cuts," *Omaha World-Herald*, November 1, 2003.

The Perilous Path of Good Intentions or How Did We Get Into This Mess in the First Place?

"Hell is paved with good intentions."

Samuel Johnson

America's and Nebraska's long-term care problems have persisted for decades. They seem impervious to comprehensive reform. One reason for this intransigence is that public officials usually give more attention to ameliorating symptoms than to understanding and eliminating the causes of problems. Ironically, the better job government does providing long-term care services to the public, the less incentive people have to pay for their own long-term care.

The best hope we have to improve long-term care for all Nebraskans and all Americans is to find new sources of private financing to supplement the public resources which seem always to be scarce and limited. We cannot find and incentivize new private financing sources, however, until we understand why they have not emerged already. How is it that America and Nebraska ended up with a welfare-financed, institution-based long-term care system in the wealthiest country in the world where no one wants to go to a nursing home?

Well-intentioned public policy created unintended market incentives that led directly to the problems we face in long-term care today. In a nutshell, this is what happened. Medicaid and Medicare began paying for nursing home care in 1965. The idea was to help Americans, who were living longer and longer throughout the twentieth century, to cope with a small, but growing need for long-term care. No one expected the nursing home costs under either program to become very large.

That expectation changed quickly. By the early 1970s, nursing home expenditures, especially under Medicaid, had exploded. People took advantage of the program, which lacked stringent eligibility controls in the beginning, to care for elderly parents whether the elders needed nursing home level of care or not. The nursing home industry maximized the new funding source and quickly built hundreds of thousands of new beds, which the public filled as fast as the industry could build them.

By the mid-1970s, the federal government started implementing a "health planning" system to control Medicaid nursing home costs. Reasoning "they can't charge us for a bed that does not exist," states were encouraged to implement "certificate of need" (CON) programs to limit the supply of nursing home beds by controlling and reducing the construction of new facilities. Nebraska installed a CON program.

The problem with controlling supply in any economic system, however, is that it tends to drive up price. That is what happened. Nursing homes started charging Medicaid more for each bed to make up for their inability to build additional beds. State Medicaid programs responded by capping Medicaid reimbursement rates. Nursing homes countered by increasing their charges to

private payers. That was the origin of the differential between Medicaid and private-pay nursing home rates.

As the gap between Medicaid and private-pay rates widened, nursing homes were faced with a dilemma. If they accepted mostly low-paying Medicaid residents, cash flow became a problem and quality suffered. If they tried to attract relatively high-paying private-pay residents, they became vulnerable to criticism for discriminating against Medicaid patients. These problems are likely to increase in Nebraska if Medicaid reimbursement rates continue to decline or fail to increase sufficiently in the future.

Over time, Medicaid residents came to predominate over private-pay residents. Medicaid rules were tightened to discourage creative Medicaid planning by means of asset transfers and shelters, but the public--aided by legal and financial specialists--found more and more creative ways to qualify for Medicaid without spending down personal resources for care. Private pay nursing home census decreased and Medicaid census increased gradually over time. Although this process has not been severe in Nebraska in the past, it could become so in the future.

The more Medicaid residents nursing homes accepted, the easier it was to fill their beds but the harder it was to survive financially. Quality of care suffered as it became harder and harder for nursing homes to hire and train quality staff in the absence of adequate revenues. In the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress mandated nursing home quality improvements but failed to provide additional financing to enable facilities to implement the mandates.

Caught between the rock of inadequate reimbursement and the hard place of quality mandates, nursing facilities in many states, including Nebraska, responded by bringing lawsuits against state Medicaid programs under the "Boren Amendment." "Boren" was part of the Omnibus Budget Reconciliation Act of 1980 (OBRA '80). It required Medicaid to pay nursing homes reimbursement rates that were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards."¹⁷ Most of the lawsuits brought under the Boren Amendment prevailed, but Congress repealed Boren in the Balanced Budget Act of 1997 (BBA '97). There is no longer any legal floor under which states cannot reduce Medicaid nursing home reimbursement rates.

In the meantime, Medicaid-financed nursing home care continued to crowd out other forms of long-term care. Public policy created the "institutional bias" in America's long-term care service delivery system by funding nursing home care almost exclusively in 1965. The public, left on its own to pay for home or community-based services, gravitated toward the publicly subsidized nursing home alternative. Consequently, cost-effective, privately financed home care, assisted living, adult day care, respite services and geriatric care management did not develop in the marketplace until decades after they might otherwise have evolved in the absence of publicly financed nursing home care. For the same reason, private long-term care insurance to pay for all levels of care did not evolve significantly for decades after 1965. It too was crowded out of the market by government-financed nursing home care.

¹⁷ Section 1902(a)(13) of the Social Security Act.

Recently, Medicaid has tried to retrofit a cost-effective home and community-based services (HCBS) system by means of programmatic "waivers" to take advantage of the potentially lower cost of caring for the frail and infirm outside of nursing homes. This approach is limited, however, by the compelling need to control public expenditures by capping HCBS waiver slots. Another problem with expanding publicly financed home and community-based services is that offering care people want (in their homes or assisted living facilities) instead of care they do not want (in nursing facilities), induces excess demand for Medicaid and reduces demand for private financing alternatives, such as long-term care insurance or home equity conversion.

Nearly forty years of providing nursing home care through Medicaid, and to a lesser degree, providing home care and nursing home care through Medicare, have anesthetized the public to the risk of long-term care. Medicare has no means test. Medicaid's long-term care eligibility restrictions on income and assets have proven extremely elastic. They allow middle- and upper-middle class Americans to avail themselves increasingly of benefits originally intended only for the poor. The public has avoided for decades, thanks to Medicaid and Medicare, what would have been far more severe financial duress resulting from long-term care crises. Therefore, most people do not place a high enough priority on paying privately for long-term care to save, invest or insure years in advance against that risk. Nor do they feel impelled to tap the equity in their homes to pay for long-term care. Consequently, more and more people are becoming dependent on public programs that are less and less able to support them financially.

The current malaise in America's and Nebraska's long-term care service delivery and financing system is the result of the well-intentioned, but often perversely counterproductive public policy incentives summarized above. To solve our long-term care problems, therefore, we will have to change the incentives in public policy which have caused the problems. This will mean finding ways to ensure that more people pay privately for long-term care so that those who have no other choice but to rely on public programs will have financially healthier programs on which to depend. By increasing private financing and reducing Medicaid dependency for long-term care, states can improve the access to and quality of care for all Americans: rich, poor and in between.

The Elephant, the Blind Men¹⁸ and Long-Term Care or Why Is It So Hard to Reform Long-Term Care?

The ancient parable of the blind men and the elephant provides a good analogy to understand long-term care policy. According to the fable, several blind men approached an elephant. One touched the animal's flank and exclaimed "a wall." Another reached for its tusk and presumed "a spear." A third thought the trunk was a snake, and so on. The lesson of the blind men and the elephant is that we do not truly understand any complicated entity until we comprehend each of its facets and all of their inter-relationships. Stakeholder groups trying to improve long-term care face similar problems to the blind men groping to identify and understand the elephant.

For example, **to government**, the challenge of long-term care is to offer the best services to the most people at the least cost. Arguably, that is what any responsible fiduciary should do with funds entrusted to its care. The irony is that the more successful government is in achieving this objective, the more people come to rely on it, the less they prepare to pay privately for their care, and the more tax resources are needed just to sustain the system, much less expand it. Unfortunately, government is already approaching the ceiling of its ability to finance long-term care even before the aging demographic crisis has begun to mount. Thus, to break the impasse, government will have to expand its approach to long-term care to encompass public policies that divert as many people as possible from dependency on public programs toward private financing alternatives.

To providers, the challenge of long-term care is to find and increase revenue sources in order to ensure quality and profitability . . . or at least solvency. Because the primary venue of long-term care has traditionally been nursing homes and the main payor has been government, nursing homes focus their public policy advocacy on increasing government reimbursement levels. They put too little effort into advocating for policies that incentivize more private financing of long-term care. Thus, the pressure on scarce public long-term care resources tends to increase whereas private financing alternatives--which are more likely to be used to purchase non-institutional levels of care--tend to languish. Long-term care providers should diversify to provide a wide range of extended care services. They should advocate strongly for public policies that target Medicaid to the most needy and encourage home equity conversion and long-term care insurance.

To most of the public, long-term care is a non-issue. Few people worry about long-term care or plan to pay for it until they face a personal health crisis. Once Dad has a stroke or Mom gets Alzheimer's, expensive care quickly becomes necessary. At that stage, families learn to their chagrin that Social Security, Medicare and Medi-Gap insurance policies are little help. To get financial assistance and to preserve as much of their wealth as possible, the path of least resistance becomes finding a way to qualify for Medicaid. Whether they spend down for care the old-fashioned way by writing big monthly checks or impoverish themselves artificially with the help of a financial adviser, the result is too often the same--another person dependent on Medicaid who might have been able to pay privately much longer with proper early planning.

¹⁸ See Appendix D for a poetic rendition of the parable of The Blind Men and the Elephant.

Public policy should awaken the public to the risk of long-term care and encourage early preparation to save, invest or insure against that cost.

Senior advocates see the "elephant" of long-term care as an underfinanced government entitlement. They are well-intentioned when they lobby for expanded public financing of long-term care. They observe inadequacies in the current system and assume that more government money poured into the same system will improve it. They may be right in the short term. But in the long run, more government financing only adds to the public's denial about long-term care risk, reduces the likelihood people will prepare to pay privately, increases the probability future generations will end up dependent on public programs, and therefore inhibits the government's ability to finance quality long-term care for anyone over time. Senior advocates should help alleviate the pressure on Medicaid and enhance the program's ability to help the poor, by encouraging public policies that divert the middle and upper-middle class to private long-term care financing sources.

Long-term care financiers see long-term care as a more or less profitable investment opportunity. These are the people and companies that provide the debt and equity capital to build, operate and maintain long-term care facilities. Once enamored of the long-term care business because of promising demographics, these investors have largely abandoned the industry. Low profitability caused by excessive dependency on inadequate public financing has driven capital out of the long-term care market. The only hope to revive long-term care financially so that investment in America's caregiving infrastructure will meet the needs of a rapidly growing population of aged is to reduce the fiscal pressure on public programs and increase the revenue flowing to long-term care facilities from private sources.

The insurance industry originally saw long-term care as a huge opportunity to profit from the "Age Wave." Insurance carriers, brokers and agents rushed into the long-term care insurance market with stars in their eyes. How could people fail to buy this wonderful new financial product that would enable them to trade their high risk of catastrophic long-term care expenses for an affordable insurance premium? What the insurance industry failed (and still fails) to realize is that the vast majority of all professional long-term care services in the United States are already paid directly or indirectly by public programs or by personal income, not assets.¹⁹ Until the public feels a greater sense of urgency about the need to pay privately for long-term care, long-term care insurance sales will remain minimal. State and federal tax deductibility or tax credits for the product will help on the margin, but most people do not fail to buy the product because it has not been genuinely tax deductible. They do not buy it because they do not think they need it. They do not think they need it, because government pays for most professional long-term care services. Thus, public policy to encourage private financing of long-term care is as critical to the insurance industry's success as it is to the survival of public programs.

¹⁹ See Stephen Moses, "So What if the Government Pays for Most Long-Term Care," *ProducersWeb.com*, July 28, 2003, http://www.centerlrc.com/pubs/Articles/so_what.htm.

Summary

Long-term care service delivery and financing in the United States in general and in the Heartland and Nebraska specifically are already in serious trouble.

- Long-term care providers lack adequate revenue to finance their services. Public funding sources for long-term care are overburdened and inadequate.
- Private financing sources for long-term care are underutilized.
- The public is asleep about long-term care until a crisis strikes, at which time government financing starts usually sooner rather than later.
- The relatively easy availability of publicly financed long-term care for today's elders reduces the next generation's sense of urgency about how to pay for long-term care.
- Institutional, medical-model extended care is most common, although the elderly almost universally prefer home-based, social-model services.

No one is happy with the current long-term care system, but deeply engrained public policy incentives keep stakeholders fighting for marginal reforms that advance their narrow self-interests.

If the system is on the verge of collapse now, imagine what will happen in thirty years when the baby-boom generation, having burdened Social Security and Medicare oppressively, begins to look toward Medicaid for the long-term care benefits it has traditionally provided. The solution to these problems is not complicated or difficult.

- We must change the incentives in public policy so that everyone who is able begins to prepare early for the risk and cost of long-term care.
- We must target Medicaid more effectively to those who have (and have had) no other means to finance their long-term care.

If we do these things successfully, private payors will create a financially healthy long-term care service delivery system on which everyone can rely. And Medicaid will be able to provide better than ever--and at less cost--for the long-term care needs of a smaller number of genuinely needy recipients.

Analysis and Recommendations

This project's stated objective was to "Produce a step-by-step plan to save the State of Nebraska \$50 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for all citizens (rich and poor alike) across the spectrum from home and community-based to nursing home care." That is a tall order on which it would have been impossible to deliver without the theoretical analysis of the problem and the potential solution we have provided above. It is time now, however, to explain specifically how Nebraska can achieve the stated objective by means of public policy initiatives that are either implementable under existing federal statutory authorities, implementable with a federal Medicaid waiver or implementable through independent state-only action outside Medicaid.

Where might the savings come from to achieve a \$50 million annual reduction in Medicaid nursing home expenditures, while increasing access to and quality of care all Nebraska citizens? **Medicaid currently pays for 54.4 percent of total nursing facility days in Nebraska. According to state staff, reducing the percentage of nursing facility days paid by Medicaid to 44.4 percent would subtract \$54 million from the cost of the program.**²⁰ Conversely, increasing the percentage of patient days paid by Medicaid to 64.4 percent would raise the program's cost by \$54 million. Over the past twenty years, the trend has been in the direction of a gradual increase in the proportion of people in nursing homes financed by Medicaid.²¹ This is true both nationally and in Nebraska. If Nebraska's Medicaid nursing facility census did increase to 64.4 percent, driving program costs up by \$54 million, the state would still be below the national average Medicaid nursing facility census of 66.7 percent.

Clearly, one major secret to reducing Medicaid's long-term care program expenditures is to reduce the proportion of Nebraskans who end up having to depend on this public assistance program for their long-term care. The more Nebraskans who pay their own way for long-term care, the more will receive their care in the settings and at the level of care they prefer. Private payers command red-carpet access to top-quality care whether in home care, assisted living or a nursing home and they can change providers if and whenever they are dissatisfied.

Private Long-Term Care Financing Alternatives

Before implementing policy and programmatic changes to divert Nebraskans from dependency on Medicaid for their long-term care, it behooves public policy makers to be certain that affordable, high-quality private-pay alternatives are readily available to the public. The two major alternatives to Medicaid long-term care financing are private long-term care insurance and home equity conversion, e.g. reverse annuity mortgages. Most of the interviewees for this project who were not directly involved in the marketing of those two products expressed doubts about their quality and affordability. It is beyond the scope of this project to defend the merits of

²⁰ Source: Personal communication, email November 7, 2003, from Emi Nyman Giles, Program Analyst, Lead, Health and Human Services System, Finance & Support, Financial Services, Financial and Program Analysis.

²¹ The proportion of patient days paid by Medicaid in Nebraska is estimated to have been 49.5 percent in 1992, 52.3 percent in 1997, and 53.7 percent in 1999. It is 54.4 percent today. Source: Personal communication, email November 12, 2003, from Emi Nyman Giles, Program Analyst, Lead, Health and Human Services System, Finance & Support, Financial Services, Financial and Program Analysis.

long-term care insurance and reverse annuity mortgages. Suffice it to say that neither product is perfect but neither are all of the criticisms lodged against them valid. The biggest problem is lack of knowledge about the products and when they are or are not suitable for specific consumers. Therefore, we propose the following recommendation.

Recommendation #1 (Private Financing Alternatives): Undertake a study of private long-term care insurance and home equity conversion.²² Identify objective standards of quality and suitability for these products and give the State's seal of approval in some formal way when these defined standards are met. Educate the public about the need to prepare to pay privately for long-term care. Explain the necessity to insure for long-term care or to tap home equity in the context of explaining changes to Medicaid eligibility rules (to be described and recommended below) which will make public financing of long-term care less easy to obtain without paying privately and spending down home equity. Reinstate a long-term care insurance policy offering for employees of the State of Nebraska and choose a carrier or carrier committed to educating state staff and marketing the product appropriately.²³ Consider the pros and cons of implementing a "Long-Term Care Partnership" program, under which the public is incentivized to purchase private long-term care insurance by a full or partial forgiveness of the Medicaid spend-down liability, and act accordingly.²⁴ Pass and implement a state tax deduction or credit²⁵ to incentivize the purchase of long-term care insurance. Finance the cost of the proposed study, educational campaign, and state tax deduction with a direct carve out of the hard-dollar savings from enhancing Nebraska's Medicaid estate recovery program in the manner recommended below.

²² For long-term care insurance, a good place to begin such a study would be Stephen A. Moses, *The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance* at http://www.centerltc.com/pubs/Myth_Report.pdf. The HIAA (Health Insurance Association of America) and the NAIC (National Association of Insurance Commissioners) are also excellent sources of information and consumer guides on long-term care insurance. Regarding home equity conversion, AARP, the NCOA (National Council on the Aging), and the NRMLA (National Reverse Mortgage Lenders Association) have extensive resources available. See especially http://www.reversemortgage.org/earlier_guidespdf.htm.

²³ Nebraska state government offered a long-term care insurance policy to employees and their families from 1997 until January 2004 through the UnumProvident insurance company. According to state personnel office staff, the insurance carrier did not follow through with successful marketing efforts, only 255 state employees signed up for the policy, the state employees' union did not advocate retaining the long-term care insurance offering, and the decision was made therefore not to offer the policy in the future.

²⁴ The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) impeded implementation of the LTC Partnerships by prohibiting programs not already implemented from exempting assets sheltered by means of the program, from estate recovery, which recovery the same legislation made mandatory. There is a strong possibility that this prohibition may be removed by federal statute, possibly in the near future. To evaluate the advisability of implementing a "Partnership" program, see especially Nelda McCall, editor, *Who Will Pay for Long Term Care?: Insights from the Partnership Programs*, Health Administration Press, Chicago, Illinois, 2001 including several chapters strongly positive toward the original Partnerships, but also Stephen Moses' Chapter 10: "The Long-Term Care Partnership Program: Why It Failed and How to Fix It," pps. 207-222.

²⁵ Opinions differ on whether to incentivize long-term care insurance purchases with a tax deduction or a tax credit. A deduction tends to benefit higher income tax payers more because it is proportionate to level of income whereas a tax credit redounds directly to the benefit of anyone who pays taxes in any amount.

Medicaid Estate Recoveries

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA '82) authorized state Medicaid programs under certain specified conditions to place liens on homes of Medicaid nursing home recipients and to recover the cost of their care from their estates. According to legislative history, the intent of Congress in TEFRA '82 was "to assure 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."²⁶ The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) made recovery of the cost of their care from Medicaid recipients' estates mandatory and a condition of receiving federal matching funds.²⁷

Nebraska has a Medicaid estate recovery program, but its recoveries are severely constrained by low staffing, limited organizational authority, and restrictions in state law. One full time equivalent (FTE) HHSS staff member, supported part time by 1.5 FTE attorneys, generates an average of \$1.2 million per year in Medicaid estate recoveries for Nebraska. State law protects the first \$5,000 of any estate from recovery if the deceased Medicaid recipient is survived by a child of any age. By comparison, Oregon, which has one of the most successful estate recovery programs in the country, invested \$1,102,000 to recover \$22,480,000 during the three-year period between July 2000 and July 2003. That is an annual recovery of nearly \$7.5 million dollars at a cost to the state of approximately \$367,000 per year, a ratio of more than \$20 recovered to \$1 invested in the cost of recovery. **If Nebraska were to recover an equivalent proportion of its long-term care expenditures from the estates of deceased recipients at a similar rate of recovery, the state would generate approximately \$12 million per year in non-tax revenue at a cost of only \$590,000 per year,²⁸ netting approximately \$10 million per year more than the state currently recovers.**

By exempting the first \$5,000 of every estate involving a surviving child of the deceased Medicaid recipient, Nebraska eliminates a huge portion of otherwise recoverable assets from potential recovery. For example, Oregon's average recovery some years ago was only \$2,000 per estate, which means Oregon generates a large proportion of its total recoveries from relatively

²⁶ United States Code, Congressional and Administrative News, 97th Congress--Second Session--1982, Legislative History (Public Laws 97-146 to 97-248) Volume 2, St. Paul, Minnesota, West Publishing Company, p. 814.

²⁷ Nevertheless, several states still have not implemented a Medicaid estate recovery program (specifically Georgia, Michigan and Texas as reported in their responses to the survey questionnaire for this study). The federal government has not yet successfully compelled them to do so nor has it withheld federal matching funds for this reason.

²⁸ These estimates are taken from Oregon's response to this study's survey questionnaire, which may be found in detail at http://www.centerlrc.org/survey_responses.pdf. Comparative potential recoveries between Oregon and Nebraska are estimated based on data provided by the Centers for Medicare and Medicaid Services (CMS) for the cost of nursing facility services in Oregon for Federal Fiscal Year (FFY) 2000 (\$184,775,241), the most recent year for which Oregon data is available. See <http://www.cms.gov/medicaid/msis/msis99sr.asp> for the source data on Oregon. Comparative data for nursing facility expenditures in Nebraska for State Fiscal Year 2002-03 (\$294,139,869) are drawn from a table titled "Medicaid Expenditures by Service Category" provided by Liz Hruska of the Nebraska Legislative Fiscal Office. Oregon's estate recoveries are approximately 4.1 percent of the states annual Medicaid nursing facility expenditures (\$7,500,000 in recoveries / \$184,775,000 in expenditures for FFY 2000 equals 4.1 percent). Applying this percentage to Nebraska's Medicaid nursing facility expenditures for SFY 2002-03 (\$294,140,000 x 4.1 percent) equals \$12,060,000 in potential estate recoveries.

small estates.²⁹ Eligibility staff in Nebraska estimated that as many as 80 percent of all Medicaid long-term care recipients retain the maximum \$4,000 in liquid assets which the state allows them to retain without affecting their eligibility. Nearly all of these recipients have surviving children. **With approximately 7,800 Medicaid recipients in nursing facilities and 2,000 in assisted living facilities at any given time, as much as \$31 million is exempted from estate recovery by Nebraska's exceptionally high \$5,000 recovery threshold.**³⁰ Five thousand dollars does not seem like a lot of money to permit people on Medicaid to keep and pass to their heirs. But, obviously, it adds up. **The germane public policy question is whether the purpose of Medicaid is to protect inheritances for heirs or to provide a safety net for access to long-term care for the needy.** Such a politically sensitive question is easy to ignore when state revenues are plentiful. When hard choices have to be made, however, about whether to raise taxes or cut services and about who will bear the financial brunt, re-examining the fundamental purpose of Medicaid becomes necessary and more feasible politically.

Recommendation #2 (Medicaid Estate Recoveries): Eliminate the exemption in state law which prevents recovery of the first \$5,000 of an estate if children survive the Medicaid recipient. Prepare state legislation to expand the definition of "estate" to include assets held in joint tenancy with right of survivorship, life estates, living trusts, etc. as permitted by OBRA '93. Pursue state statutory authority to require attorneys or personal representatives of Medicaid recipients and nursing homes to inform the state whenever a recipient dies.³¹ Seek state statutory authority for automatic recovery of small accounts held by Medicaid recipients in nursing homes and financial institutions on the model of programs in Oregon and Wisconsin which generate high recoveries with low effort. Assign state staff or hire a private contractor to research successful estate recovery programs in other states, including Oregon. Develop and implement a plan to build up Nebraska's estate recovery program.

Examples of a few procedures used by some other states which Nebraska should consider include the following. Establish an accounts receivable system including contracts for deeds and open-ended mortgages which permit recipients and their families to retain assets (such as the family home or farm) while repaying Medicaid benefits over time.³² Track and recover from the estates of surviving spouses of deceased Medicaid recipients and from former recipients who leave Medicaid before death.³³ Collect personal property as well as real estate and have a fiduciary maintain and auction the proceeds on contingency, e.g. investment-grade jewelry, paintings, Persian rugs, automobiles, etc.³⁴ Give incentive awards to outstanding recovery specialists whenever possible; waive merit compensation rules if necessary to permit bonuses on

²⁹ Oregon does not recover from every estate regardless of size. The state bases the decision on whether to recover on the cost effectiveness of pursuing recovery.

³⁰ 9,800 recipients times 80 percent who retain at least \$4,000 equals \$31,360,000.

³¹ We understand a bill to require such reporting (LB 240) will be considered by the state legislature.

³² Nebraska may already have a limited accounts receivable system of this kind.

³³ State staff indicated they have a state plan amendment proposed and pending before the Centers for Medicare and Medicaid Services which will authorize spousal recoveries if approved.

³⁴ Nebraska currently ignores home furnishings and personal property in determining Medicaid eligibility in most cases. Families are permitted to remove property from the homes of their parents who are on Medicaid with impunity. Exceptions include collections or other items of value which Medicaid applicant/recipients voluntarily acknowledge owning. Such items are also supposed to be considered in determining asset eligibility so they should have been spent down prior to the recipient's becoming eligible for Medicaid and should therefore not be an issue at the point of estate recovery.

the basis of actual recoveries generated. (Many additional estate recovery procedures and techniques are documented in earlier state-level reports by the author and are available upon request.)³⁵

Medicaid IS Welfare

Medicaid eligibility workers in all three local offices visited for this study³⁶ indicated that they routinely advise long-term care applicants and/or their personal representatives about ways to protect otherwise nonexempt assets from Medicaid spend-down requirements. One worker even stated "I say this is not welfare, this is Medicaid." Workers also said that representatives of the Area Agencies on Aging often provide similar advice as well as referrals to elder law and Medicaid planning attorneys. Medicaid applicants are entitled to know the rules and Medicaid eligibility workers should inform them of their rights. On the other hand, Medicaid is a means-tested public assistance program. It IS welfare. Income and assets protected from spend-down requirements do speed up eligibility for Medicaid, increase program costs, divert resources from other coverage groups, and exacerbate state fiscal problems. Therefore, it is very important to understand exactly what Medicaid is paying for and why.

A good example of how substantial sums are diverted from private long-term care financing to a Medicaid expenditure is the exemption for burial expenses. Medicaid recipients are allowed to place \$3,000 in an irrevocable burial trust fund. In addition, they may pre-pay burial expenses, such as the casket, burial space, opening and closing of the grave and the headstone, in any amount.³⁷ Workers report that upwards of 90 percent of all Medicaid long-term care recipients have irrevocable burial trust funds and/or prepaid burial costs averaging in total between \$6,500 and \$8,000. (By comparison, counties often provide burials for indigents at a cost of \$1,000 or less.) Assuming only 80 percent of Nebraska's 9,800 Medicaid recipients residing in nursing homes or assisted living facilities have set aside an average of \$6,500 for their burials, we can estimate conservatively that **\$51 million** has been diverted from private long-term care financing to a Medicaid expenditure in this way. Nebraska also allows Medicaid applicants to exempt assets for **a spouse's** prepaid burial expenses which would increase the amount of assets so sheltered significantly. **The key public policy question is whether scarce Medicaid resources are best used to pay for long-term care for the needy or to subsidize burials for recipients and their spouses in order to relieve their heirs of this expense.**³⁸

It should be noted that funeral companies use the Medicaid burial cost exemption as a marketing tool for their prepaid burial policies. One example is the Funeral Directors Life Insurance Company's product marketed by Premier Senior Marketing, Inc. of Norfolk, Nebraska. They

³⁵ For example, see *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois* at http://www.centerltc.com/pubs/MAGIC_Bullet.pdf and *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care* at <http://www.centerltc.com/pubs/FLORIDAREP.pdf>.

³⁶ Medicaid eligibility workers were interviewed for this study at three diverse locations: Fairbury for a rural office; Lincoln for a suburban office; and Omaha for an urban office.

³⁷ Although there is no limit on prepaid burial expenses, the state does require an itemized list of items purchased and their cost. Total burial costs reported usually do not exceed \$12,000 and average between \$6,500 and \$8,000.

³⁸ Nebraska Medicaid has little flexibility to reduce the exemption for burial expenses because of restrictions in federal law, specifically Supplemental Security Income (SSI) rules, which apply and are not waivable according to CMS officials. This issue will need to be addressed at the federal level.

offer a "One-of-a-kind Prefunding Burial Trust Program" which "allows the client to set aside up to \$25,000 . . . which may be protected from attachment by creditors, such as nursing homes, **Medicaid**, hospitals, lawyers, and others." (Emphasis added.) According to its website, "FDLIC will pay the funeral home for its services first, and then pay the contingent beneficiary any remaining funds within the next business day. It's that simple!" and their irrevocable trust is "protected from Medicaid spend down."³⁹ Eligibility workers in Nebraska said that some heirs of Medicaid recipients have attempted to recover a portion of their parent's prepaid burial fund (exempted for purposes of qualifying him or her for Medicaid) by cremating the parent at a lower cost than burial and claiming the difference in cost from the funeral home or insurance company as reimbursement.

In addition to exempting assets through prepaid burial expenses, eligibility workers mentioned many other ways they advise long-term care applicants to reduce their countable resources. Strategies differ depending on whether or not the person applying for Medicaid has a spouse in the community. In spousal cases, families may be advised to pay off a home mortgage and other debts, put on a new roof, buy a new furnace or washer and dryer, purchase a sprinkler system, or upgrade to a better car. When the Medicaid applicant is single, Nebraska requires sale of the home⁴⁰ and does not exempt an automobile⁴¹ so that excluding assets by improving a home or purchasing a car would not be helpful for a single person. Single applicants may be encouraged instead to purchase a telephone, television, lift chair, clothes, and other exempt personal items. Eligibility workers told us that applicants are often very reluctant to spend funds in this way, having been frugal with their money all their lives. Sometimes it takes encouragement from their adult children to get them to expedite Medicaid eligibility by purchasing exempt assets.

A final way in which substantial income and assets are exempted from Medicaid spend-down is through the "spousal impoverishment" protections passed in the Medicare Catastrophic Coverage Act of 1988 (MCCA '88). Before this legislation passed, impoverishment was a serious problem for healthy spouses remaining in the community when an ill spouse became institutionalized on Medicaid. Medicaid eligibility rules required that all but a few thousand dollars of the couple's joint assets and all but a few hundred dollars of their monthly income be spent down to qualify for Medicaid long-term care benefits. MCCA '88 changed the rules and allowed the spouse at home to retain up to \$1,500 per month of income and half the couple's joint assets, not to exceed \$60,000, without affecting the Medicaid spouse's eligibility. These amounts were pegged to inflation and have increased to \$2,267 per month and \$90,660, respectively, as of 2003. They will increase to \$2,319 and \$92,760 in 2004.

Although these income and asset protections are considered by some people in certain parts of the country to be grossly inadequate, eligibility workers in rural Nebraska told us that this "grand and glorious program" protects "large assets" for relatively well-to-do people. They were making the point that Nebraska's spousal impoverishment protections are extremely generous compared, for example, to the eligibility strictures that single, disabled people must meet to

³⁹ Source for these quotes : <http://www.premiersmi.com/fdlc.htm>.

⁴⁰ Sale of the home is required after six months if it is shown that the recipient is unable medically to return to the home and no exempt relatives resides in the house.

⁴¹ Nebraska Medicaid requires nursing homes and assisted living facilities to provide transportation for recipients and reasons, therefore, that an automobile need not be exempted for a single recipient.

qualify for help from Medicaid. No one wants to see spousal impoverishment protections reduced, but if costs must be cut and the alternatives under consideration are even more draconian, then this is an area in which substantial savings can be achieved. Washington State reduced its Community Spouse Resource Allowance from the maximum of \$90,660 to \$40,000 in 2003 and expects to save approximately \$6.0 million per year in long-term care and associated medical expenditures (such as pharmacy costs) under Medicaid.⁴² A similar reduction in Nebraska, based on the relative sizes of the two states' Medicaid nursing home programs, could be expected--all other things being equal--to produce **a savings of \$3.1 million per year.**

Recommendation #3 (Medicaid IS Welfare)

As explained above, very large sums of money are exempted from private long-term care financing because of exclusions from Medicaid countable assets permitted under state and federal law. Most of these exclusions are mandated by federal law and would therefore require a waiver or federal law change to stop. The state of Nebraska should (1) explore its options with regard to counting or exempting specific asset classes from the Medicaid spend-down requirement, (2) formulate explicit guidelines for Medicaid eligibility workers with regard to advice and recommendations they should volunteer to applicants, (3) consider whether spousal impoverishment protections are set at the optimal level and (4) clarify to state staff and to the public through a long-term care educational campaign that although Medicaid exempts certain amounts of income and assets, the program IS public welfare and not an entitlement for protecting inheritances.

Control Asset Transfers

Undoubtedly, the largest leakage of assets from potentially private long-term care expenditures in Nebraska occurs because of asset transfers that result--intentionally or unintentionally--in premature Medicaid eligibility and increased Medicaid costs. **The single most important insight gained in this study was that Nebraskans' biggest assets--their homes, farms, ranches and other businesses--are frequently transferred from the older generation to the younger generation many years before long-term care is needed and for reasons possibly unrelated to the potential future need for long-term care.** Several interviewees for this project acknowledged that such transfers have already been accomplished in their own families for general estate planning purposes.

The reason this observation is so important is that Medicaid looks back only three years for general asset transfers and five years for transfers of assets into a trust when determining whether resources have been transferred for less than fair market value in order to qualify for Medicaid. Assets transferred within those time frames incur an eligibility penalty in months equal to the total amount of assets transferred for less than fair market value divided by the average monthly cost of a nursing home in the state. Any assets transferred outside the three-year and five-year boundaries--no matter how large--are not countable for purposes of determining Medicaid eligibility. Thus, when one generation of Nebraskans passes the family farm or any other wealth

⁴² Source: The Washington State Senate Ways and Means Committee website as reported in a personal communication (email November 18, 2003) by Gerald Reilly, a public policy consultant and former Washington State Medicaid Director and Executive Director of the Washington Health Care Association.

to the next generation, whether or not for the purpose of qualifying for Medicaid, the net effect is that such resources do not interfere with Medicaid long-term care eligibility if and when such care becomes necessary three (or five) years later.

Several interviewees explained that early asset transfers are usually done to avoid probate or estate taxes, often without explicit contemplation of the need for long-term care. Most Nebraskans, we were told, are fiercely independent and self-sufficient. They give little thought to long-term care while they are still healthy. They assume "in our family, we take care of ourselves." When a long-term care crisis occurs, however, reality quickly sets in. Professional care is very expensive and family members are often unavailable or unable to provide appropriate care themselves. At that point, the family is apt to seek assistance from the state through Medicaid. By then, however, assets that might otherwise have been available to pay for their long-term care have long ago been transferred out of the elders' ownership, albeit quite possibly for reasons unrelated to long-term care planning. The net effect is that Medicaid ends up absorbing costs that could have been paid privately had the assets not been transferred earlier.

The Nebraska bar is well aware of Medicaid planning techniques to shelter or transfer assets for the purpose of qualifying for the program's long-term care benefits. In a *Nebraska Law Review* article titled "Estate Planning for Farm and Ranch Families Facing Long-Term Health Care," attorney Roger A. Mceowen wrote: "Some assets are exempt from the income and asset restrictions in the Medicaid law. The beginning point in counseling clients facing potential long-term health care and an application for Medicaid is to arrive at a knowledge of what assets a client may continue to own without having those assets being counted toward the Medicaid eligibility limits."⁴³ He continues in the article to explore numerous Medicaid planning techniques. For example:

A specific estate planning technique different from the traditional asset and trust planning concepts, involves income-producing property used in a trade or business. Under a 1990 amendment to the Medicaid law, all income-producing property used in a trade or business can be excluded from countable resources for Medicaid eligibility purposes. This is a very important planning tool for farm and ranch clients because the amendment applies to all property used in a trade or business that is essential to a person's self-support regardless of the value or rate of return.⁴⁴

Another Medicaid planning technique involves the use of retained life interests. A retained life interest is a limited interest in property lasting only for the lifetime of the life tenant.⁴⁵

Practitioners have another available weapon in the Medicaid planning arsenal for those clients owning stock in a closely held family corporation. . . . The

⁴³ Roger A. Mceowen, "Estate Planning for Farm and Ranch Families Facing Long-Term Health Care," *Nebraska Law Review*, Volume 73, 1994, (73 *Neb. L. Rev.* 104, p. 7). Footnote references have been omitted in the quotes from this article but may be found in the original.

⁴⁴ *Ibid.*, p. 11.

⁴⁵ *Ibid.*, pps. 11-12.

appropriate Medicaid planning strategy . . . may be to work the potential Medicaid applicant into a minority position by making a series of gifts during life outside of the applicable look-back period until the applicant is in a minority position. Then, the strategist should argue that the applicant is no longer able to sell the stock and therefore should be immediately eligible for Medicaid benefits. This strategy allows the practitioner to preserve the asset in question for the applicant and the applicant's family.⁴⁶

Another planning technique involves using the Medicaid appeals process to divert as much income as possible from the institutionalized spouse to the community spouse in order to bring the community spouse up to a specified minimum level of monthly income. Utilizing the Medicaid appeals process to increase the Community Spouse Resource Allowance (CSRA) can be an invaluable tool for protecting family assets by diverting them to the community spouse.⁴⁷

Mceowen's article also contains a section on "Protecting the Medicaid Beneficiary and Beneficiary's Estate from Reimbursement Claims."⁴⁸ Medicaid planners know that evading the program's estate recovery mandate is equally as important as protecting their clients' assets from Medicaid spend-down requirements in the first place.

Finally, Mceowen provides the following advice on long-term care insurance: "[I]f a particular client is married and all or nearly all of the individual's assets can be sheltered using various Medicaid planning techniques and available allowances, then long-term care insurance is not a high priority."⁴⁹ On the other hand, "Perhaps the most cost effective way to use long-term care insurance in the overall Medicaid plan utilizes insurance to protect assets by financing the cost of care during the period of Medicaid ineligibility. For example, if a client makes transfers that would result in thirty-six months of ineligibility and the client's medical condition will permit the underwriting of a long-term care policy, it may be advisable to have the client purchase a policy with just under three years of benefits This procedure will allow the client to receive insurance benefits until the Medicaid benefits are available."⁵⁰ Such a tactic of coordinating private insurance with Medicaid eligibility minimizes the role of private insurance and maximizes the fiscal burden on Medicaid.

Another problem related to asset transfers involves the process of determining "deprivation." As explained above, when a long-term care applicant or recipient is found to have transferred assets for less than fair market value for the purpose of qualifying for Medicaid,⁵¹ an eligibility penalty is supposed to be imposed equal to the number of months the person could have paid privately for care had the assets not been transferred. Under existing federal rules, there are many ways to manipulate this requirement to reduce its negative effect. For example, using the "half a loaf" gambit, potential Medicaid long-term care applicants are advised to give away half their assets,

⁴⁶ *Ibid.*, p. 13.

⁴⁷ *Ibid.*, p. 13.

⁴⁸ *Ibid.*, pps. 17-18.

⁴⁹ *Ibid.*, p. 13.

⁵⁰ *Ibid.*, p. 14.

⁵¹ Assets transferred prior to application are presumed to have been transferred for the purpose of qualifying for Medicaid. This presumption is rebuttable by the applicant or his or her personal representatives.

incur half the penalty that would have occurred if they had transferred all their assets, and then spend down with the remaining assets in half the time than would otherwise have been required. Eligibility workers explained that, for the same reason the half-a-loaf strategy works, potential applicants can give away the equivalent of one month's nursing home charge (usually around \$4,000 per month in Nebraska) without incurring an eligibility penalty beyond the month of the transfer. Because the state only imposes an eligibility penalty when the amount transferred equals or exceeds the cost of a month in the nursing home, people can actually transfer \$4,000 plus \$3,999 each month and still avoid any transfer of assets penalty beyond the month of the transfer.

Finally, eligibility workers expressed frustration at the frequency of deprivation cases which seem to apply for long-term care assistance a month or two after any eligibility penalty has run its course. This is important because, under federal law, transfer of assets eligibility penalties are imposed from the date of the asset transfer, not from the date of Medicaid application or eligibility. Thus, someone could transfer \$100,000 to anyone for any reason without compensation, wait 26 months,⁵² apply for Medicaid long-term care benefits, and incur no transfer of assets penalty. Eligibility workers in Omaha showed us four examples of cases in which something similar to this strategy occurred and they alluded to many more. When asked to give a "conservative" estimate of the percentage of cases in which this occurs, they responded that 20 percent of their long-term care cases averaging \$25,000 "on the low end" would be their "best guess." Hypothetically projecting this estimate statewide would suggest that **up to \$49 million may have avoided the transfer of assets penalty given Nebraska's current long-term care caseload.**⁵³ Such a projection is not valid without verification and is possibly much higher than such verification would confirm. The point is that no one knows for sure without further analysis. In the meantime, eligibility workers are spending a great deal of time analyzing and verifying individual "deprivation" cases only to find when they complete the process that no period of ineligibility or only a very short eligibility penalty applies. Given the extremely large workloads of these Medicaid eligibility staff, they find this seemingly wasted effort exceptionally frustrating. Omaha eligibility workers suggested that starting the eligibility penalty at the date of Medicaid application, or better yet, at the date when the asset transfer is discovered (especially if it was originally concealed) would prevent the end runs around transfer of assets rules that they perceive to be occurring.

Recommendation #4: (Control Asset Transfers)

Nebraska should determine how much asset value is being transferred out of the ownership of older citizens that could have been used for their long-term care, but having been transferred, results in their dependency on Medicaid. The quickest and easiest way to make this determination is to select a valid random sample of cases from the total Medicaid long-term care caseload and subject them to a far more comprehensive and exhaustive review than is possible to conduct routinely for all cases. Such a review would allow the state to project an estimate,

⁵² The transfer of assets penalty for a \$100,000 transfer would be 25 months based on a monthly nursing home cost of \$4,000. Because the penalty period begins with the date of the transfer, Medicaid eligibility would be free and clear as of the 26th month.

⁵³ 7,800 nursing home recipients plus 2,000 in assisted living facilities equals 9,800 times 20 percent times an average of \$25,000 equals \$49 million.

within a range of values and probabilities, of the total assets so transferred. If the total is sufficiently large to warrant corrective action, the state could explore several courses of action. State probate law could be amended to discourage asset transfers that have the effect, intentional or otherwise, of expediting Medicaid long-term care eligibility. Nebraska could consider joining the states of Minnesota, Connecticut and Massachusetts in requesting a Medicaid waiver (1) to allow a longer transfer of assets look-back period and (2) to begin the eligibility penalty at the date of Medicaid qualification or long-term care admission, whichever is later.⁵⁴ Connecticut projects a five year savings of \$87 million from implementing this waiver.⁵⁵ Based only on comparison of the size of their nursing home programs, **the comparable savings to Nebraska per year from implementing the same waiver would be \$4.2 million.**⁵⁶

Get Control of Annuities and Trusts

Widespread, systematic and sophisticated Medicaid estate planning is not nearly as prevalent in Nebraska as in many other states . . . yet.⁵⁷ Nevertheless, the use of annuities and trusts to qualify for Medicaid long-term care benefits was mentioned frequently in our interviews by eligibility policy staff, eligibility workers, and by Mary Wilson, an elder law attorney. Annuities are used in qualifying for Medicaid because they allow an applicant to convert cash (a countable asset) into an income stream which, although it must be used to offset the cost of care, may not interfere with eligibility and may protect some principal. Trusts, if irrevocable and prepared early enough, can be used effectively to transfer assets for purposes of qualifying for Medicaid and to avoid estate recovery liability. Field eligibility workers routinely refer all problematic trust and annuity cases to central office eligibility experts who review the cases and inform the field how to handle them. This is a very sensible approach to a complicated problem which we would have recommended if Nebraska were not doing it already. Central office eligibility policy

⁵⁴ Details on these states' waiver requests may be found at <http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp> . Simply click on a state on the map, then click the waiver in question to find full details on the state's proposal.

⁵⁵ See Connecticut's answer to question # 5 of the survey questionnaire for this study at http://www.centerltc.org/survey_responses.pdf .

⁵⁶ In 2001, Connecticut's Medicaid nursing home expenditures were \$1,060.3 million and Nebraska's were \$258.3 according to the Centers for Medicare and Medicaid Services (<http://www.cms.gov/medicaid/msis/msis99sr.asp>) . If Connecticut expects to save \$17.4 million per year from the proposed 1115 waiver, the comparable figure for Nebraska would be \$4.2 million. Obviously, Nebraska should develop its own estimate of potential savings based on characteristics unique to the state.

⁵⁷ For a good idea of what could develop in Nebraska if nothing is done to stop the spread of Medicaid estate planning, see <http://www.medicaidhelp.com/ne> which promises: "Nebraska Medicaid Qualification and Eligibility Save Your Assets & Still Qualify for Medicaid For Nursing Home or Other Long Term Care Click Here! This site is designed to provide information for single Nebraska residents who wish to save their assets and savings for their families and still qualify for assistance from Medicaid for long term care needs. Long term care can include: nursing home, adult foster care, assisted living facility, residential care facility, in-home care, etc. Available in All 50 States! . . . The Financial Aid Center for Long Term Care Using techniques approved in both Federal and Nebraska State Medicaid rules, the Financial Aid Center for Long Term Care, via the MAPPTM video program, can teach you how to transfer assets to your family and still qualify for Medicaid - quickly! Did you know that single people can legally transfer up to 100%* of their assets to their family and still quickly qualify for Medicaid to pay for Nursing Home or other long term care expenses - no matter what you've been told, even if you are already in care? *Try it yourself - click on our copyrighted MAPP Savings CalculatorTM and find out how much your family could save!"

specialists see three to five such cases a day. They are time-consuming and annoying. For example:

The reason we have so many trusts and annuities in this state is that they are a great cash cow for the attorneys. Families could have done a straight transfer of assets and saved attorney's fees, so they get unhappy with the lawyer. We have 10 or 15 questions of this kind raised per week and many are within the law. We see a lot of transfers or trusts which were done outside the five-year look-back period. We determine if it is possible to invade the trust. Three to five of them per week are inappropriate.⁵⁸

Omaha elder law attorney Mary Wilson expressed concern about the growth in use of annuities to qualify for Medicaid. She believes consumers have been seduced into buying annuities, for the purpose of facilitating Medicaid eligibility, which do not always properly serve that purpose and may leave the consumer unprotected while generating large commissions for insurance agents. She states that a big marketing push for such annuities has been underway in Nebraska for several months.⁵⁹

Recommendation #5: (Get Control of Annuities and Trusts)

Based on indications from the interviewees for this study and on extensive references to problems associated with the Medicaid eligibility treatment of trusts and annuities in the survey questionnaire responses received from other states,⁶⁰ we recommend that Nebraska and other concerned states confer with representatives of the Centers for Medicare and Medicaid Services and propose federal legislative action to correct the problems. It does not appear that a satisfactory resolution is possible without federal statutory intervention.

Fight Financial Abuse of the Elderly

Efforts by friends, family members, guardians or financial charlatans to qualify a frail or infirm elder for Medicaid long-term care benefits sometimes cross over into financial abuse. Interviewees for this project provided several examples of such cases⁶¹:

A young couple asks for a \$20,000 loan and then disappears leaving a parent "impoverished" and eligible for Medicaid.

A daughter moves in with her elderly mother, starts buying expensive shoes, etc., and soon \$10,000 has disappeared and the mother is approved for waived home care services.

⁵⁸ Source: Meeting with central eligibility policy staff on October 15, 2003.

⁵⁹ Source: Meeting with elder law attorneys, including Mary Wilson, on October 28, 2003.

⁶⁰ See the summary of state survey questionnaire responses in Appendix A and the full online version of their responses at http://www.centerlrc.org/survey_responses.pdf.

⁶¹ Source: Meeting with eligibility workers in Lincoln, NE on October 16, 2003.

A Social Security "protective payee" collects a senior's monthly check, but fails to make the required contribution toward the Medicaid recipient's cost of care to the nursing home.

We were told by nursing facility representatives that such practices are "rampant" and that they "seem to be going on more and more." One eligibility worker guessed that perhaps five percent of cases involve some form of financial abuse. Several workers expressed frustration that they put a lot of work into documenting cases of financial abuse but then the responsible authorities usually refuse to take action. A proprietary nursing facility representative said "If you call APS [Adult Protective Services] to tell them, they do nothing." An eligibility worker said: "Nothing ever happens to people who cheat. They get investigated by APS but the cases do not go to court. Like the daughter who took Mom's Social Security money. The county attorney said they were not going to prosecute, because 'we are not bill collectors for the nursing home.'"

We were told that no one in the state attorney general's office specializes in elder abuse. It was not known whether the state has a hotline for elder abuse, as it does for child abuse. In Nebraska, financial abuse of the elderly is primarily the responsibility of the individual county attorneys, many of whom work part time and are overburdened already with other criminal prosecutions. An HHSS attorney explained that the state can only take legal action if the state has been defrauded. He pointed out that when a senior's assets are stolen resulting in impoverishment and Medicaid eligibility, the crime is against the senior and not against the state. Thus, he reasoned, the state has no recourse. This is a "Catch 22" that Nebraska should try to correct.

Recommendation #6: (Fight Financial Abuse of the Elderly)

Recognize that Medicaid estate planning often shades into financial abuse of the elderly. Change state law if necessary to authorize the Medicaid program to become subrogated to the rights of program recipients and to pursue their and the state's interest in recovering stolen or expropriated assets. When appropriate, Nebraska should petition the court to appoint conservators in cases of suspected financial abuse. Oregon uses conservators in this way to relitigate expropriative divorce decrees, reverse illegal transfers, invade trusts, partition undivided property, and to maintain and sell properties, etc. This same method could be used to stop the theft of recipients' income by "protective payees" which is a significant problem for nursing homes in Nebraska because it deprives them of the patient's contribution to cost of care. By using private attorneys compensated on contingency, these initiatives can be taken at no cost to the state while generating considerable non-tax revenue for the Medicaid program.

Revisit Nebraska's 1997 Long-Term Care Plan

Much of what this current report says and recommends has been said, recommended, and disregarded before. In June 1996, the Nebraska Health and Human Services System (HHSS) undertook a major study of long-term care services. That study resulted in a report published in May 1997 titled "Nebraska's Long-Term Care Plan: Putting the Needs of Nebraskans First."⁶²

⁶² Nebraska Health and Human Services System, "Nebraska's Long-Term Care Plan: Putting the Needs of Nebraskans First," Lincoln, Nebraska, May 1997.

The report concluded that too many Nebraskans received their long-term care under Medicaid in nursing homes, and that increasing home and community-based care alternatives could "slow down the growth of Medicaid long-term care expenditures" and "realize cumulative savings of more than \$130 million over the next ten years."

The "Nebraska Long-Term Care Plan" proposed two general kinds of change. First and foremost were numerous recommendations to make the Medicaid program's long-term care benefits more attractive and cost-effective by discouraging nursing home institutionalization and encouraging home care and assisted living. Second and less prominent were recommendations to discourage Medicaid planning and to encourage private financing sources for long-term care such as insurance and home equity conversion. Since the Plan's publication in 1997, most of its proposals to make Nebraska's Medicaid long-term care benefits more attractive have been implemented. Unfortunately, however, very few of the Plan's proposals to enhance private financing sources have been put in place.

The following quotes from a December 2, 1996 report by The Long-Term Care Insurance Work Team indicate thoughtful analysis and sensible recommendations that Nebraska policy makers should revisit and reconsider.

Many states, including Nebraska, face major challenges in providing affordable, comprehensive long-term care services. The greatest obstacle to the provision of these services is the over-reliance on the Medicaid program to fund long-term care services, particularly nursing home care. Because of the budgetary constraints at both the state and federal level, it is critical to find innovative ways of financing and delivering long-term care service.⁶³

Despite the need for long-term care services and the projected impact on the state's Medicaid budget, there has not been a coordinated effort to educate and inform the public about these problems. Most educational efforts have been focused on the need for Medicaid estate planning. As a result, individuals tend to be more knowledgeable about sheltering individual assets in order to qualify for Medicaid long-term care financing than about the broader public policy issues.⁶⁴

The Work Team also concluded that "Medicaid funds should only be used for those who really need them and that manipulating loopholes to gain eligibility is not consistent with the program's intent."⁶⁵ It stated further that "changes may be needed in Medicaid laws and regulations in order to take advantage of home equity loans (reverse mortgages) in financing long-term care. . . . Reverse mortgages have the potential to help older homeowners purchase long-term care services and perhaps long-term care insurance."⁶⁶

⁶³ The Long-Term Care Insurance Work Team, "Strategies to Encourage the Purchase of Long-Term Care Insurance," December 2, 1996, p. 1.

⁶⁴ *Ibid.*, pps. 1-2.

⁶⁵ *Ibid.*, p. 11.

⁶⁶ *Ibid.*, p. 11.

Recommendation #7: (Revisit Nebraska's Long-Term Care Plan)

Nebraska policy makers should dust off the 1997 study "Nebraska's Long-Term Care Plan" and reconsider its analysis and recommendations related to discouraging Medicaid dependency and encouraging private long-term care financing alternatives. In general, the report recommended "changing current laws and policies related to Medicaid estate planning to enhance the State's ability to prevent transfers of assets affecting Medicaid eligibility" and "creating an environment that would encourage the purchase of long-term care insurance policies in the private sector to reduce reliance on Medicaid and other government services."⁶⁷ More specifically, the general report and the Medicaid planning and long-term care insurance sub-committee reports contain additional analysis and recommendations that should be reviewed again and considered in the context of the findings and recommendations of the current report.

Attack the "Entitlement Mentality" and Underscore Personal Responsibility

This report has identified several sources of potential savings to the Medicaid long-term care program that could simultaneously increase access to quality care for all Nebraskans by enhancing private long-term care financing sources. For example:

According to state staff, reducing the percentage of nursing facility days paid by [Nebraska] Medicaid to 44.4 percent [from the current 54.4 percent] would subtract **\$54 million** from the cost of the program.⁶⁸

If Nebraska were to recover an equivalent proportion of its long-term care expenditures from the estates of deceased recipients at a similar rate of recovery [compared to Oregon], the state would generate approximately **\$12 million** per year in non-tax revenue at a cost of only \$590,000 per year.⁶⁹

With approximately 7,800 Medicaid recipients in nursing facilities and 2,000 in assisted living facilities at any given time, as much as **\$31 million** is exempted from estate recovery by Nebraska's exceptionally high \$5,000 recovery threshold.⁷⁰

Assuming only 80 percent of Nebraska's 9,800 Medicaid recipients residing in nursing homes or assisted living facilities have set aside an average of \$6,500 for their burials, we can estimate conservatively that **\$51 million** has been diverted from private long-term care financing to a Medicaid expenditure in this way.⁷¹

When asked to give a "conservative" estimate of the percentage of cases in which [a property transfer] occurs, [eligibility workers] responded that 20 percent of

⁶⁷ Nebraska Health and Human Services System, "Nebraska's Long-Term Care Plan: Putting the Needs of Nebraskans First," Lincoln, Nebraska, May 1997, Executive Summary, page un-numbered.

⁶⁸ See page 15 of this report.

⁶⁹ See page 17 of this report.

⁷⁰ See page 18 of this report.

⁷¹ See page 19 of this report.

their long-term care cases averaging \$25,000 "on the low end" would be their "best guess." Hypothetically projecting this estimate statewide would suggest that up to **\$49 million** may have avoided the transfer of assets penalty given Nebraska's current long-term care caseload.⁷²

To tap these potential resources, Nebraska will need to pass laws, operationalize programs, and possibly seek waivers and/or changes to federal law. Unless the state also confronts some critical social and cultural trends, however, significant savings and changes in consumer behavior will be very difficult to achieve.

Interviewees for this study identified three major trends in public attitudes that impede progress. First is a sense of entitlement to publicly financed benefits. Second is the flip side of the first: a reduction in the sense of personal responsibility. The third follows from the first two: denial of the risk of long-term care. These trends are inter-related in the following way. A sense of entitlement to public benefits reduces the likelihood that people will take personal responsibility to plan for long-term care which increases the probability they will end up relying on Medicaid which sends the message to the next generation that long-term care is not a financial risk for which they need to plan. This downward spiraling cycle has been at work at least since the start of Medicaid and Medicare in 1965.

Here is what we heard from various categories of interviewees:

A **hospital discharge planner** said "Families do not want to have any financial obligation. They do not want to pay for nursing home care. They see it as an entitlement for the children. I had an attorney tell me that we can structure our assets in a legal way so we don't have to pay for nursing home care."⁷³

A **Medicaid eligibility worker** stated "The adult children say 'that's my inheritance. I'm entitled to that.' We keep telling them that 'inheritance' means 'AFTER their parents die.'"⁷⁴

An **elder law attorney** said: "The absolute root of the problem is this: why is the public willing to pay \$80,000 for a Cadillac instead of \$20,000 for a Chevy, but unwilling to spend anything for long-term care?"⁷⁵

A **central office eligibility policy staff member** said: "People in this state do view it as an entitlement to get Medicaid to pay for their nursing home care. A tremendous amount of planning goes on. People want to leave the farm to the kids and the family attorney wants to help them make it happen. There are many straight out transfers outside the 36 month look-back period that we never hear about."⁷⁶

⁷² See page 24 of this report.

⁷³ Source: Meeting with hospital discharge planners on October 31, 2003.

⁷⁴ Source: Meeting with eligibility workers in Lincoln local office on October 16, 2003.

⁷⁵ Source: Meeting with elder law attorneys on October 28, 2003.

⁷⁶ Source: Meeting with central office eligibility policy staff on October 15, 2003.

A **proprietary nursing facility representative** said: "Medicaid is not a welfare program anymore. It is an entitlement to everyone because government has made it so. Why would you pay privately when you can divest your assets? This is a huge problem. It pits the nursing home against the community. People see everyone doing it."⁷⁷

A **chamber of commerce official** said: "I would expect Medicaid planning to be as big here as elsewhere because our older population is very large and Nebraskans have considerable wealth. Our culture here is 'take personal responsibility,' but human nature and the kids quickly take over. They think they have a right to the money. In rural communities the ranch and farm owners' goal is to pass on the business to the next generation."⁷⁸

A **legislator** said: "There is still a consensus that Medicaid is for the needy but that is probably changing. In public, most people won't admit that they want Medicaid. They won't buy into public welfare if you call it that."⁷⁹

The tide is obviously turning against Nebraska's traditional Heartland values of personal responsibility and self-sufficiency. On the other hand, there is still a strong foundation of solid values to shore up and build upon by acting resolutely and soon.

Recommendation #8: (Attack the "Entitlement Mentality" and Underscore Personal Responsibility)

Pass a "Sense of the Legislature" resolution to be signed by Governor Johanns and publicized throughout the state of Nebraska explaining the state government's position on long-term care financing. Consider using this "Heartland Manifesto," recommended in an earlier report.⁸⁰

"The Heartland Manifesto"

[Nebraska] has very limited dollars available for public assistance. The state's first responsibility is to take care of the truly poor and disadvantaged.

The middle class and well-to-do should pay privately for long-term care to the extent they are able without suffering financial devastation.

Prosperous people who rely on public assistance for long-term care should reimburse the taxpayers before giving away their wealth to heirs.

Seniors and their heirs who wish to avoid such recovery from the estate should plan ahead, purchase private long-term care insurance, and pay privately for the care of their choice when the time comes.

⁷⁷ Source: Meeting with proprietary long-term care providers on October 31, 2003.

⁷⁸ Source: Meeting with representatives of the business community on October 27, 2003.

⁷⁹ Source: Meeting with state legislators and staff on October 14, 2003.

⁸⁰ Stephen A. Moses, "The Heartland Manifesto: How To Finance Long-Term Care for Middle America: A Case Study in South Dakota," LTC, Inc., Seattle, Washington, 1996, p. iii.

The four main drivers of the Nebraska state budget are (1) K-12 education; (2) higher education; (3) corrections; and (4) Medicaid. The state currently faces a projected \$198 million budget shortfall.⁸¹ In the past 18 months, the Legislature has made significant cuts to Medicaid and to the higher education budget. More cuts or tax increases are likely to be unavoidable. Education is easiest to cut because, unlike the "entitlements" for public aid and Medicaid, legislators have more control over it. To maximize public support for the initiatives proposed in this report, we recommend the following strategy.

Present every proposal in the form of an alternative. For example:

Shall we (A) preserve the \$5,000 exemption from Medicaid estate recoveries that protects inheritances or (B) cut higher education commensurately?

Shall we (A) preserve the average \$6,500 Medicaid eligibility exemption for prepaid burial expenses or (B) increase taxes by an equal amount.

Shall we (A) rein in the practice of early asset transfers that result in premature or unnecessary Medicaid long-term care eligibility or (B) further cut benefits to poor children and the disabled to make up the difference.⁸²

Presented in this manner, i.e., in the form of a Hobson's Choice⁸³ or a Morton's Fork,⁸⁴ the difficult measures necessary to reform Medicaid long-term care may be more acceptable to policy makers and citizens.

⁸¹ Robynn Tysver, "Budget May Need More Cuts," *Omaha World-Herald*, November 1, 2003.

⁸² The American Academy of Pediatrics explains why Medicaid benefits are so critical to poor children in Nebraska at http://www.nachri.org/nachri/resources/pdfs/mfs_ne.pdf. "WHY DO CHILDREN ON MEDICAID NEED YOUR HELP? Medicaid faces serious financial threats that endanger the health of Nebraska's children. An estimated 33,619 Nebraska children-more than one in 14-are uninsured. If Medicaid funding is cut, that number will grow dramatically. And since the federal government pays at least 59% of the total cost of Nebraska's Medicaid program, the state will lose \$14.70 in federal funding for every \$10 it cuts from its state Medicaid budget."

⁸³ "Colloquial English phrase for a choice that is not a choice - either there is only one option, or two options that are equally undesirable or virtually identical." See <http://c2.com/cgi/wiki?HobsonsChoice>.

⁸⁴ "Morton's Fork describes a choice between two equally unpleasant alternatives, or two lines of reasoning that lead to the same unpleasant conclusion." See <http://c2.com/cgi/wiki?MortonsFork>.

The Heartland Model for Long-Term Care Reform

The Heartland Model for long-term care reform is uncomplicated. The fundamental idea is to build on the strengths and reverse the weaknesses of the long-term care systems in the states of America's Heartland. Then expand the Heartland Model to other parts of the country where the strengths are weaker and the weaknesses stronger.

The Heartland strengths include:

- A solid base of traditional values emphasizing personal responsibility and self-sufficiency.
- Relatively low dependency on Medicaid for long-term care and a relatively high number of private payers.
- The highest long-term care insurance market penetration rates in the country, although far below what they could and should be.
- High home ownership which indicates Heartland seniors have wealth to protect by means of insurance and wealth to tap for long-term care by means of home equity conversion.
- Relatively healthy long-term care provider markets based on heretofore generous public and private reimbursements which have supported quality and minimized tort liability.

Build on these strengths by tightening Medicaid eligibility requirements, enforcing Medicaid liens and estate recoveries, incentivizing private insurance and home equity conversion, and educating the public about the risk and cost of long-term care.

The Heartland's long-term care weaknesses include:

- Alarmingly high proportions of elderly people now and in the future and relatively high rates of nursing home institutionalization.
- Rapidly increasing Medicaid long-term care expenditures that drive pressures to reduce provider reimbursements.
- Staff shortages and growing quality concerns driven by shortfalls in public financing combined with flat or declining private financing.
- Skyrocketing liability insurance premiums caused mostly by huge liability settlements against long-term care facilities and companies outside the Heartland.
- Weak markets for private long-term care insurance and home equity conversion products caused by low public awareness of cost and risk caused in turn by the fact that government pays for most long-term care.
- A growing "entitlement mentality" underscored by increasing Medicaid planning and by Medicaid improvements, such as expanded home care and assisted living, in the absence of strong enough eligibility controls.
- Severe budgetary pressures that require hard choices about what and where to cut or whom to tax more, pressures that will likely increase exponentially as the Age Wave hits.

Confront these weaknesses by targeting Medicaid long-term care benefits more narrowly to the needy, by preventing the use of Medicaid as "inheritance insurance" through strong estate recoveries, by providing better reimbursement for the full continuum of care for a smaller

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Medicaid caseload, by encouraging public awareness of long-term care risk and cost, by incentivizing the purchase of private long-term care insurance and the use of home equity conversion, and by working with other states and the federal government to reform long-term care service delivery and financing to remove the constraints in federal law that obstruct change.

The Heartland Model for Long-Term Care Reform is a start. Ultimately, more radical change will be necessary. Today, Medicaid has become far more than a long-term care safety net for the poor. It is the primary payor for long-term care, period. As long as most people can ignore the risk of long-term care, avoid the premiums for private insurance, and shelter or transfer their biggest asset (the home), other personal priorities will supersede their planning for long-term care and the status quo will continue to decline.

Policy makers can act now or soon to reverse the perverse incentives in public policy that put most of the financial burden of long-term care on an underfinanced welfare program. Or they can do nothing, let the current system collapse, and thus destroy the safety net for the poor. The impact for prosperous Americans will be the same. One way or another, the \$1.8 trillion of home equity held by seniors in America will be at risk to finance long-term care for home owners in the future.

Appendix A: Survey Says

As part of this project, the Center for Long-Term Care Financing sent the following survey on "Controlling Medicaid Long-Term Care Costs" to the Directors of all 50 state Medicaid programs plus the District of Columbia (DC). The purpose of the survey was to provide context for our findings in Nebraska and to suggest ideas for analysis and corrective action from other parts of the country. We also hope that the contact information provided with the survey response compilation will facilitate communication between state staff throughout the country who are struggling to find solutions for the problems facing Medicaid.

What follows is a brief summary of the responses we received from 22 states and DC. A total of 28 states did not respond, usually giving as their reason staff shortages caused by budget crises. Also included below are some "highlight" quotes that may be of particular interest.

Anyone who would like to dig deeper can find a 50-page compilation of all survey responses online at http://www.centerltc.org/survey_responses.pdf. To make it possible for readers to follow up on specific questions and answers, this same online .pdf file also includes contact information for staff who prepared the answers from each state.

Occasionally, a state's survey response will refer to "attachments" or "enclosures." If you are interested in reviewing these items, we ask that you request them directly from the state by contacting the responsible individual identified for each state.

The survey questions follow in lower case. The states responses are in UPPER CASE CHARACTERS.

Controlling Medicaid Long-Term Care Costs

1. Please answer the following questions on Medicaid eligibility policy:

How is income eligibility for Medicaid long-term care determined in your state? Please explain briefly.

Medically needy? If so, what medical and other expenses are deductible from income to determine Medicaid eligibility? (SEE THE COMPILED RESPONSES FOR DETAILS.)

CT, DC, GA, IN (209B), LA, ME, MN, MT, NC, ND, UT

Income cap? If so, how common are "Miller Income Trusts" and what effect have they had on Medicaid eligibility since being authorized in OBRA '93?

AL (?), AZ (529), AR (428, 2.7%), DE (VERY COMMON), KY (A/O 9/03), MI (NONE), MS (FEW), NV (ANYONE), OR (1238, 6%), SC (7%), TX (1%)

NEITHER: OH

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What is the Community Spouse Resource Allowance (CSRA _____) and the Minimum Monthly Maintenance Needs Allowance (MMMNA _____) for your state? Have these standards changed in the past three years? If so, from what to what?

(MOST STATES RESPONDED WITH THE FEDERALLY MANDATED CSRA AND MMMNA LEVELS. VERY FEW RESPONDING STATES HAVE LOWERED OR INCREASED THEIR MINIMUMS RECENTLY)

KY DROPPED FROM MAXIMUMS TO CSRA=\$20,000 AND MMMNA=\$1,515 ON 9/1/3

Do you allow the "transfer of assets before income" to bring a community spouse up to the MMMNA?

YES: IN, ME, NC, NV, ND (TRY NOT), OH, SC, TX, UT

NO: AL, AZ, AR, CT, DC, DE, GA, KY, LA, MN, MT, OR

NO ANSWER: MI, MS

Is the home considered exempt as long as an "intent to return" is in effect? If you impose some other requirement, please explain.

YES: AL, AZ, AR, CT (6 MO. REVIEW), DC, DE, GA, KY, LA, ME, MI, MN (REASONABLE), MS, NC, NV, OR, SC, TX, UT

NO: IN (209B), MT, ND, OH

2. Has a study of Medicaid estate planning (e.g., purchase of exempt assets, transfers, annuities, trusts, "just say no," etc.) and/or liens and estate recoveries been done in your state? If yes, please send copies of reports or executive summaries and key recommendations as appropriate.

YES: AZ, CT, MT, OH

NO: AL, AR, DC, DE, GA, IN, KY, LA, ME, MI, MN, MS, NC, NV, ND, OR, SC, TX, UT (COMMENTS)

NOTABLE COMMENTS:

AZ: IN 2000, WE CONDUCTED A STUDY REGARDING THE USE OF ANNUITIES IN COMMUNITY SPOUSE CASES AND MADE RECOMMENDATIONS FOR CHANGES IN FEDERAL LAW. THIS WAS SUBMITTED TO CMS AND OUR CONGRESSIONAL DELEGATION BUT NO ACTION WAS TAKEN. A COPY OF OUR RECOMMENDATIONS IS INCLUDED AS A SEPARATE ATTACHMENT.

CT: YES. IN THE MID 90'S THE BRACELAND INSTITUTE (INSTITUTE FOR LIVING) CONDUCTED A STUDY; IN 1997 AN AUDIT OF PUBLIC ACCOUNTS WAS

CONDUCTED AND MOST RECENTLY A REVIEW OF TRANSFER ACTIVITY OF IMPENDING LTC APPLICATIONS WAS CONDUCTED FOR THE CALENDAR YEAR 2000 BY THEIR DEPARTMENT (WAIVER 1115) GO TO: [HTTP://WWW.DSS.STATE.CT.US/PUBS/TOA_PROPOSAL.PDF](http://www.dss.state.ct.us/pubs/toa_proposal.pdf) TO FIND A COPY OF THE TRANSFER OF ASSETS WAIVER 1115 PROPOSAL THAT THE CT DEPT. OF SOCIAL SERVICES SUBMITTED IN FEB 2002; IF YOU CAN NOT GET TO THIS LINK, GO TO [WWW.DSS.STATE.CT.US](http://www.dss.state.ct.us). LOOK UNDER PUBLICATIONS AND THEN NEWS AND UPDATES.

OH: YES, A STUDY WAS REQUESTED BY THE LEGISLATURE IN 1998, TO BE RELEASED BY 1999. THERE WAS A RELEASE OF THE REPORT IN SEPT. 1999 TO THE SENATE, HOUSE, AND GOVERNOR. THE REPORT, MEDICAID ESTATE PLANNING AND ESTATE RECOVERY IN OHIO, IS ATTACHED. SOME BUT NOT ALL OF THE RECOMMENDED CHANGES HAVE BEEN IMPLEMENTED.

UT: UTAH HAS NOT DONE A FORMAL STUDY ON ESTATE PLANNING. WE HAVE CONCERNS ABOUT ANNUITIES AND HAVE SUBMITTED A PROPOSAL TO CHANGE THE ANNUITY POLICY TO SANCTION TRANSFERS THAT ALLOW THE COMMUNITY SPOUSE TO HAVE ASSETS ABOVE THE SPOUSAL ASSESSMENT ALLOWANCE OR INCOME ABOVE THE MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE. THIS POLICY WAS SUBMITTED TO AND REJECTED BY REGIONAL AND FEDERAL CMS. WE ARE CONSIDERING RESUBMITTAL OF THIS POLICY BECAUSE OF THE WISCONSIN V. BLUMER SUPREME COURT DECISION THAT HELD THAT IT IS APPROPRIATE FOR THE SECRETARY OF DHHS TO LEAVE TO THE STATES THE INTERPRETATION OF A PROVISION OF THE STATUTE, WHEN THE STATUTE DOES NOT CLEARLY OR UNAMBIGUOUSLY REQUIRE A PARTICULAR READING OF THE PROVISION IN QUESTION. IN THIS PARTICULAR MATTER THEY WERE REFERRING TO SECTION 1924 OF THE SOCIAL SECURITY ACT.

3. Has your state taken action to control Medicaid estate planning, to close unintended eligibility "loopholes" or to encourage private financing alternatives for long-term care? Please explain and provide relevant reports and memoranda; statutory, regulatory or policy language.

YES: AL (COMMENTS), AZ (COMMENTS), CT (1115 WAIVER), IN (COMMENTS), KY (COMMENTS), MN (COMMENTS, 1115 WAIVER), LA (COMMENTS), MT, NC (COMMENTS), ND (COMMENTS), OH (COMMENTS), SC (COMMENTS), TX (COMMENTS), UT (COMMENTS)

NO: AR, DC, DE, GA, MI, MS, NV, OR

NO ANSWER: ME

NOTABLE COMMENTS: RESPONDING STATES PROVIDED EXTENSIVE COMMENTS IN RESPONSE TO THIS QUESTION, ESPECIALLY WITH REGARD TO EFFORTS MADE TO CONTROL THE USE OF ANNUITIES AND TRUSTS FOR PURPOSES OF MEDICAID ESTATE PLANNING. READERS ARE ENCOURAGED TO

REVIEW THE DETAILED RESPONSES AT
[HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) . A FEW TYPICAL
COMMENTS FOLLOW:

AL: ALABAMA ALLOWS AN ADDITION OF LONG-TERM CARE COSTS PAID BY A PRIVATE LONG-TERM CARE INSURANCE POLICY TO BE ADDED TO THE RESOURCE LIMIT FOR THE INSTITUTIONALIZED SPOUSE. (EX. LONG-TERM CARE POLICY PAID \$150,000 FOR THE 3 YEARS PRIOR TO MEDICAID APPLICATION. RESOURCE LIMIT FOR APPLICANT WOULD BE \$152,000.) WE HAVE A PENDING REGULATION IMPLEMENTING EXISTING POLICY THAT RESTRICTS THE USE OF LUMP SUM ANNUITIES TO SHELTER ASSETS.

AZ: THE PROBLEM OF HAVING COMMUNITY SPOUSE CASES WITH ANNUITIES WORTH HUNDREDS OF THOUSANDS OF DOLLARS CONTINUES BECAUSE OF THE FEDERAL INTERPRETATION THAT SECTION 1917(C)(2)(B) OF THE SOCIAL SECURITY ACT ALLOWS UNLIMITED TRANSFERS FROM A MARRIED INDIVIDUAL WHO REQUIRES LONG TERM CARE SERVICES TO THEIR SPOUSE WHO IS STILL RESIDING IN THE COMMUNITY. THE LAW ALSO ALLOWS FOR UNLIMITED TRANSFERS FROM EITHER THE INSTITUTIONALIZED SPOUSE, OR FROM THE SPOUSE REMAINING IN THE COMMUNITY, TO A THIRD PARTY FOR THE BENEFIT OF THE SPOUSE IN THE COMMUNITY.

KY: EFFECTIVE MARCH 2003 KENTUCKY HAS CHANGED POLICY TO COUNT ANNUITIES WITH BALLOON PAYMENTS AS A TRANSFER OF RESOURCES FOR LESS THAN FAIR MARKET VALUE.

NC: N.C. HAS ENACTED LAW REQUIRING THE SANCTIONING OF TRANSFERS OF TENANCY-IN-COMMON INTEREST IN REAL PROPERTY, WHICH IS AN EXCLUDED RESOURCE.

ND: THE DEPARTMENT OF HUMAN SERVICES HAS TRIED TO CLOSE LOOPHOLES, AND THERE HAVE BEEN SOME LEGISLATIVE EFFORTS TO ENCOURAGE THE PURCHASE OF LONG TERM CARE INSURANCE, BUT INEXPLICABLE CMS DIRECTIVES AND EFFECTIVE LOBBYING BY THE ELDER BAR COUNTER THE RESULTS OF THESE EFFORTS.

OH: OHIO HAS REVISED ITS RULES ON TRANSFER OF RESOURCES . . . OHIO ODJFS STAFF DO PUBLIC SPEAKING ENGAGEMENTS ENCOURAGING PEOPLE TO PURCHASE LTC INSURANCE IF THEY ARE INTERESTED IN PRESERVING THEIR ASSETS.

SC: RECENTLY, WE HAVE TIGHTENED LOOPHOLES REGARDING THE MISUSE OF PROMISSORY NOTES AND SPECIAL NEEDS TRUSTS. . . . WE MODIFIED OUR POLICIES ON SPECIAL NEEDS TRUSTS BY ADDING ACCOUNTABILITY FOR ANY LOANS MADE FROM THE TRUSTS.

UT: WE CLOSED AN ANNUITY LOOPHOLE WHERE CLIENTS WERE ATTEMPTING TO TAKE OUT ANNUITIES AND RECEIVE SMALL SUMS MONTHLY WITH A LARGE BALLOON PAYMENT WHEN THE ANNUITY MATURED.

4. Did your state respond to provisions in OBRA '93, HIPAA '96 ("throw granny in jail") and BBA '97 ("throw granny's lawyer in jail") regarding Medicaid estate planning, liens and estate recoveries? If so, how? How did the repeal of the germane provision in HIPAA '96 and the nonenforcement of the BBA '97 proscription on Medicaid planning affect your efforts to control the practice of Medicaid planning?

YES: ND (COMMENTS)

NO: AL (COMMENTS), AZ (COMMENTS), AR, CT, DC, DE, GA, LA (COMMENTS), ME, MI, MN, MS, NC, NV, OH (COMMENTS), OR (COMMENTS), SC, TX, UT

NO ANSWER: IN, KY, MT

NOTABLE COMMENTS: SEVERAL RESPONDING STATES COMMENTED THAT MEDICAID ESTATE PLANNING ACTIVITIES DECLINED AFTER HIPAA '96 BUT PICKED UP AGAIN AFTER NONENFORCEMENT OF BBA '97.

AL: WE HAD SEEN A REDUCTION IN MEDICAID ESTATE PLANNING PARTICIPATION BY ATTORNEYS BEFORE THE NON ENFORCEMENT OF THE BBA '97 PROVISIONS WAS ANNOUNCED.

AZ: ARIZONA TOOK NO SPECIFIC ACTION TO ENFORCE EITHER HIPAA '96 OR BBA '97. AT THAT TIME, WE HAD A NUMBER OF ELDER LAW ATTORNEYS WHO WERE REPRESENTING PERSONS IN THE APPLICATION PROCESS. THE EXISTENCE OF THOSE PROVISIONS BY THEMSELVES WERE SUFFICIENT TO INHIBIT ATTORNEYS FROM BEING VERY CREATIVE IN THE WAY THAT THEY WERE ASSISTING INDIVIDUALS IN "REPOSITIONING THEIR ASSETS" TO QUALIFY FOR OUR PROGRAM. HOWEVER, ONCE HIPAA '96 WAS REPEALED AND ATTORNEY GENERAL RENO DECIDED NOT TO ENFORCE BBA '97, WE EXPERIENCED A VIRTUAL EXPLOSION IN THE CREATIVE TACTICS BEING USED. . . . IN ADDITION, WE ALSO WITNESSED A NUMBER OF INDIVIDUALS WHO WERE NOT ATTORNEYS CREATE BUSINESSES WITH THE SOLE PURPOSE OF QUALIFYING PERSONS FOR LONG TERM CARE, FOR A PRICE. IN EFFECT, THE DELETION OF THOSE PROVISIONS CREATED A WHOLE NEW COTTAGE INDUSTRY.

LA: IT IS OUR OPINION AND EXPERIENCE THAT WHEN THE LAW WAS OVERTURNED, IT TOOK AWAY A SIGNIFICANT DETERRENT /THE CHILLING EFFECT ON THE PRACTICE OF ESTATE PLANNING.

ND: WE ATTEMPTED TO KEEP A LID ON WITH THE OBRA '93 CHANGES BY IMPOSING THE LIMITS PERMITTED. WE HAVE RESISTED CMS DIRECTIVES INTENDED TO SUPPORT ASSET GIVE-AWAYS. WE HAVE VIGOROUSLY OPPOSED

AND LITIGATED TRUST-BASED EFFORTS TO SHELTER ASSETS. WE HAVE VIGOROUSLY EXAMINED CASES FOR DISQUALIFYING TRANSFERS. BUT THE NORTH DAKOTA LEGISLATURE HAS STEERED A COURSE THAT HAS THE EFFECT OF ALLOWING INDIVIDUALS WITH ASSETS VASTLY EXCEEDING THE SPOUSAL IMPOVERISHMENT LIMITS TO MAINTAIN THOSE ASSETS IN THE HANDS OF COMMUNITY SPOUSES WHO PURCHASE ANNUITIES.

5. Is there a strong Medicaid estate planning bar in your state? Are seminars on how to qualify for Medicaid long-term care benefits without spending down advertised? Do attorneys call Medicaid eligibility workers seeking information on exclusions and exemptions? How serious an issue do you consider Medicaid planning to be? Please elaborate.

NOTABLE COMMENTS:

AL: YES. ALABAMA HAS A VERY STRONG ESTATE-PLANNING BAR, AS WELL AS SEVERAL PRIVATE CONSULTING FIRMS THAT SPECIALIZE IN THIS TYPE OF ASSISTANCE. A PROGRAM ON PUBLIC ACCESS TELEVISION OFTEN FEATURES ELDER LAW FIRM LAWYERS WHO DISCUSS WAYS TO DO MEDICAID ESTATE PLANNING. THIS IS A GROWING PROBLEM IN THIS STATE, AS WE RECEIVE MORE AND MORE REQUESTS FOR HEARINGS FROM THESE LAWYERS AND/OR CONSULTING FIRMS.

AZ: WE HAVE A STRONG MEDICAID ESTATE PLANNING BAR IN ARIZONA AND SOME OF THEM HOLD SEMINARS TO CREATE BUSINESS. . . . WE CONSIDER MEDICAID PLANNING TO BE A VERY SERIOUS ISSUE SINCE IT RESULTS IN PERSONS WHO ARE NOT ACTUALLY INDIGENT QUALIFYING FOR OUR LONG-TERM CARE PROGRAM. IN MANY WAYS, IT HAS BECOME A PROGRAM FOR THE RICH AS WELL AS THE POOR.

AR: THERE SEEMS TO BE A DECLINE IN MEDICAID ESTATE PLANNING BAR ACTIVITY. AT ONE TIME THERE WERE FREQUENT "MEDICAID" ADS IN THE NEWSPAPER BUT THEY ARE NOT AS FREQUENT NOW. ATTORNEYS DO CONTACT ELIGIBILITY WORKERS. WORKERS ANSWER SPECIFIC QUESTIONS ABOUT POLICY BUT DO NOT GIVE ADVICE.

CT: YES. SEES ADVERTISEMENTS CLAIMING THEY CAN TEACH PEOPLE HOW TO PREVENT STATES AND NURSING HOMES FROM "GOBBLING UP THEIR ASSETS." MEDICAID PLANNING IS VERY SERIOUS. THE DEPT. OF SOCIAL SERVICES WAIVER 1115 PROJECTS A SAVINGS OF \$87 MILLION OVER THE NEXT 5 YEARS IF IMPLEMENTED.

DC: YES, THERE IS A STRONG MEDICAID ESTATE PLANNING BAR IN THE DISTRICT OF COLUMBIA. YES, MAA IS AWARE THAT ATTORNEYS IN THE DISTRICT PROVIDE SEMINARS ON WHO TO QUALIFY FOR MEDICAID LONG-TERM CARE BENEFITS. ATTORNEYS IN THE DISTRICT OF COLUMBIA ARE VERY ACKNOWLEDGEABLE ABOUT MEDICAID ELIGIBILITY.

GA: LIKE IN MANY OTHER STATES, WE BELIEVE THAT WE HAVE A VERY SERIOUS ISSUE WITH FINANCIAL ADVISERS AND ATTORNEYS HOLDING SEMINARS THROUGHOUT THE STATE. THESE TWO ENTITIES ADVERTISE THAT THEY CAN SHOW PEOPLE "HOW TO GET MEDICAID TO PAY FOR THEIR LONG TERM CARE SERVICES" WITHOUT HAVING TO PURCHASE LONG TERM CARE INSURANCE OR DIVESTING THEIR ASSETS. OF COURSE THEY TRY TO GET THE PEOPLE TO PURCHASE ANNUITIES OR ESTABLISH TRUSTS WITH THEIR ORGANIZATIONS. THESE PRACTICES ARE INDEED HAVING A GREAT NEGATIVE IMPACT ON THE LONG-TERM CARE INSURANCE INDUSTRY IN OUR STATE.

MI: NO. [Michigan was the only responding state that answered this question "no."]

MN: YES, THERE IS A STRONG MEDICAID ESTATE PLANNING BAR. ANNUAL SEMINARS DEVOTED TO THE TOPIC ARE HELD, AND PRESENTATIONS ARE MADE AT A NUMBER OF RELATED LEGAL EDUCATION CLASSES. TO DATE, ATTORNEYS HAVE BEEN RELUCTANT TO LITIGATE IN THIS STATE, BUT THIS MAY BE CHANGING.

MS: ACTIVE, BUT NOT STRONG. . . . NOT SERIOUS AT THIS TIME.

MT: IT IS A GROWING AREA. ARE SEMINARS ON HOW TO QUALIFY FOR MEDICAID LONG-TERM CARE BENEFITS WITHOUT SPENDING DOWN ADVERTISED? YES FOR LAWYERS AND OTHER PROFESSIONALS AND PRIVATE CITIZENS. STATE STAFF HAS EVEN BEEN ASKED TO PARTICIPATE. DO ATTORNEYS CALL MEDICAID ELIGIBILITY WORKERS SEEKING INFORMATION ON EXCLUSIONS AND EXEMPTIONS? YES WEEKLY TO THE STATE POLICY SPECIALISTS AND ALSO TO LOCAL OFFICES OF PUBLIC ASSISTANCE. HOW SERIOUS AN ISSUE DO YOU CONSIDER MEDICAID PLANNING TO BE? GROWING AT AN ALARMING RATE BASED ON ELIGIBILITY STAFF FEEDBACK. WOULD BE AN AREA THAT WOULD BE CONTINUED TO BE LOOKED AT IN THE FUTURE.

NV: VERY STRONG. SEMINARS ARE CONDUCTED. ATTORNEYS DO CONTACT EMPLOYEES. THE STATE EVALUATES EACH COURT PETITION TO OPPOSE IF NECESSARY.

NC: RELATIVE TO STATES LIKE NY, CA, FL, IL, AND NJ, WE DO NOT HAVE A STRONG MEDICAID ESTATE-PLANNING BAR IN NC, BUT OUR NUMBERS AND LEVEL OF EXPERTISE ARE GROWING. . . . MOST ATTORNEYS ARE HELPING THE HEALTHY SPOUSE PRESERVE ENOUGH LIVE ON, AND ARE ADVISING CLIENTS ABOUT CONVERTING COUNTABLE ASSETS INTO NONCOUNTABLE ASSETS (SUCH AS BUYING BURIAL CONTRACTS, MAKING HOME REPAIRS, OR PURCHASING HOUSEHOLD GOODS).

ND: VERY SERIOUS PROBLEM. NORTH DAKOTA, LIKE MANY OTHER STATES, FACES SOME FISCAL DIFFICULTY. AS A CONSEQUENCE, WE HAVE HAD TO

REDUCE COVERED SERVICES, AND REDUCE COVERAGE FOR CHILDREN AND FAMILY GROUPS. THESE CUTS ARE DEEPER THAN WOULD HAVE BEEN NECESSARY BECAUSE OF MEDICAID PLANNING. I AM NOT TOO CONCERNED ABOUT THE ELDER LAW BAR. THESE FOLKS MAKE A SERIOUS EFFORT TO FOLLOW THE LAW, AND ARE SUBJECT TO SIGNIFICANT ETHICAL CONSTRAINTS. MANY NORTH DAKOTANS, BEING A CONSERVATIVE BUNCH, DECIDE NOT TO ENGAGE IN MEDICAID PLANNING WHEN PRESENTED WITH GOOD ADVICE ABOUT THE VARIOUS ALTERNATIVES. WHAT I WORRY ABOUT ARE THE INSURANCE SALES REPS. REGULATION IS VERY LIMITED, ETHICS ARE NOT SUBJECT TO ANY RIGOROUS ENFORCEMENT BY ANYONE, AND THE SALES GROUP IS OFTEN TRAINED AND INFLUENCED BY VERY BAD INFORMATION FROM COMPANIES WITH NO REAL KNOWLEDGE OF MEDICAID. (FOR INSTANCE, IT IS NOT UNUSUAL TO FIND INSURANCE COMPANY TRAINERS WHO DON'T KNOW THAT STATES' MEDICAID PROGRAMS DIFFER AS TO ELIGIBILITY REQUIREMENTS AS WELL AS COVERED SERVICES AND OFFERED COVERAGES.)

OH: OHIO'S MEDICAID ESTATE PLANNING BAR IS NOT AS AGGRESSIVE AS WE HAVE HEARD IN SOME OTHER STATES; HOWEVER OHIO ATTORNEY BILL BROWNING IS THE NEW NATIONAL PRESIDENT OF THE NATIONAL ASSOCIATION OF ELDER LAW ATTORNEYS. SEMINARS ARE OFFERED AND ADVERTISED HEAVILY. ATTORNEYS OFTEN CALL MEDICAID ELIGIBILITY POLICY ANALYSTS AT THE STATE LEVEL SEEKING INFORMATION ON THE STATE'S ELIGIBILITY POLICIES. . . . MEDICAID POLICY ANALYSTS CONSIDER IT A SERIOUS ISSUE BECAUSE OF ACCOMPANYING LOSSES IN REVENUE DURING TIMES OF SEVERE BUDGET CONSTRAINTS AND PROGRAM CUTBACKS (E.G., CAP ON NURSING HOME RATES, LOSS OF COVERAGE FOR SOME ANCILLARY SERVICES PASSED IN BIENNIAL BUDGET BILL).

OR: YES, THERE IS A STRONG MEDICAID ESTATE PLANNING BAR IN OREGON. WITH THE SPOUSAL IMPOVERISHMENT CHANGES, THE OREGON STATE BAR ESTABLISHED AN ELDER LAW SECTION THAT DEALS SPECIFICALLY WITH MEDICAID AND ESTATE PLANNING.

SC: SOUTH CAROLINA HAS A VERY STRONG MEDICAID ESTATE PLANNING BAR - ALSO KNOWN AS THE ELDER LAW BAR. THE ELDER LAWYERS SPONSOR SEVERAL CLES (CONTINUING LEGAL EDUCATION) EVERY YEAR, AND THE NUMBER IS INCREASING. ATTORNEYS CONSISTENTLY CALL OUR ELIGIBILITY DIVISION SEEKING INFORMATION ON EXCLUSIONS AND EXEMPTIONS. MEDICAID PLANNING IS A VERY SERIOUS ISSUE IN OUR STATE.

TX: YES. MEDICAID ESTATE PLANNING COMPLICATES THE ELIGIBILITY DETERMINATION PROCESS RESULTING IN WORKLOAD IMPACTS ON STAFF AND THE NEED TO WORK CLOSELY WITH THE OFFICE OF GENERAL COUNSEL ON LEGAL ISSUES BEYOND THE EXPERTISE OF POLICY STAFF.

UT: ESTATE PLANNING FOR MEDICAID HAS NOT BEEN A BIG PROBLEM IN UTAH IN THE PAST. I HAVE REQUESTED STAFF REFER PHONE CALLS FROM ESTATE

PLANNERS AND ATTORNEYS TO ME. THE NUMBER OF CALLS IS ON THE INCREASE AND I BELIEVE MEDICAID ESTATE PLANNING IS ON THE INCREASE. WE DO HAVE ATTORNEYS AND ESTATE PLANNERS WHO PRESENT SEMINARS ON PLANNING TECHNIQUES. OUR GREATEST CONCERN ON THESE IS THAT SOME USE SCARE TACTICS THAT RUSH SENIORS INTO PURCHASING THINGS SUCH AS ANNUITIES BEFORE THOROUGHLY ANALYZING WHETHER OR NOT THEY WILL LIKELY GO INTO AN NURSING HOME OR IF THERE ARE OTHER MORE VIABLE OPTIONS.

6. What are the most commonly used artificial impoverishment techniques in your state? How common are these practices? Do you know, or if you had to guess, what percentage of Medicaid nursing home eligibility cases involve some form of divestiture or sheltering? Please elaborate.

RESPONSES TO THE QUESTION RE PERCENTAGE OF CASES INVOLVING DIVESTITURE OR SHELTERING:

AL: 25%
AZ: 7.5%
AR: <5%
CT: 33%
DC: 10%
DE: NA
GA: 10%
IN: NA
KY: NA
LA: 10%
ME: NA
MI: 15%
MN: "FAIRLY COMMON"
MS: NA
MT: 7.5% AND GROWING
NC: DK
ND: 50%
NV: NA
OH: "GROWTH"
OR: 5%
SC: COMMENTS
TX: COMMON
UT: LOW, BUT LIKELY TO GROW

NA = NO ANSWER

NOTABLE COMMENTS:

AL: TRANSFER OF ASSETS TO CHILDREN PRIOR TO LOOK-BACK PERIOD.
TRANSFER OF ASSETS INTO TRUSTS OR ANNUITIES.

AZ: TRANSFERS TO FAMILY MEMBERS OR THE COMMUNITY SPOUSE THROUGH THE PURCHASE OF AN IRREVOCABLE STREAM OF INCOME ANNUITY. . . . FOR COMMUNITY SPOUSE CASES, ANNUITIES ARE USED TO TRANSFER FUNDS TO A THIRD PARTY FOR THE NEEDS OF THE COMMUNITY SPOUSE IN EXCESS OF THE COMMUNITY SPOUSE RESOURCE ALLOWANCE. . . . ANNUITIES ARE ALSO BEING USED TO AVOID ESTATE RECOVERY. . . . LIFE ESTATES WITH POWERS - A PERSON TRANSFERS HOME PROPERTY TO A RELATIVE, BUT RETAINS A LIFE ESTATE INTEREST IN THE PROPERTY WITH THE RIGHT TO SELL THE PROPERTY DURING HIS OR HER LIFETIME. . . . TRANSFERS DURING A MONTH OF AN AMOUNT THAT IS A LITTLE LESS THAN THE PRIVATE PAY RATE (AMOUNT CHARGED IN THE COMMUNITY FOR NURSING HOME CARE). . . . ELDER LAW ATTORNEYS AND PROFESSIONAL REPRESENTATIVES ENCOURAGE APPLICANTS AND PROSPECTIVE APPLICANTS TO IMPLEMENT PLANNED GIFTING, A PROCESS WHEREBY THE APPLICANT MAKES MONTHLY TRANSFERS OF CASH RESOURCES TO ONE OR MORE FAMILY MEMBERS IN AMOUNTS JUST UNDER THE PRIVATE PAY RATE. IN OTHER INSTANCES, THEY ENCOURAGE STRATEGIC GIFTING PRIOR TO THE LOOK BACK PERIOD. . . . HOME PROPERTY PLACED IN A TRUST. . . . TRANSFERS OF EXCLUDED RESOURCES. . . . ARIZONA IS SEEING SITUATIONS WHERE THE APPLICANT GIFTS AN EXCLUDED VEHICLE, AND THEN USES CASH RESOURCES TO PURCHASE ANOTHER EXCLUDED VEHICLE. THIS ALLOWS THE PERSON TO TRANSFER A VALUABLE ITEM WITHOUT PENALTY, AND THEN PURCHASE ANOTHER AS A WAY OF SPENDING DOWN RESOURCES.

IN: COMMON PRACTICES ARE THE PURCHASE OF ANNUITIES, INTERESTS IN INCOME -PRODUCING PROPERTY (WHICH IS EXEMPT IN INDIANA), TRANSFERS OF ASSETS.

LA: TRANSFERRING OR DONATING ASSETS FOR NO COMPENSATION OR VERY LITTLE COMPENSATION, PLACING ASSETS IN EXCLUDABLE TRUSTS AND ANNUITIES, CHANGING A BANK ACCOUNT OWNER'S NAME FROM THE APPLICANT TO ANOTHER PERSON, ADDING A NAME TO THE ACCOUNT AND DECLARING THAT NONE OF THE MONEY IN THE ACCOUNT BELONGS TO THE APPLICANT, DECLARING THE VALUE OF A COUNTABLE RESOURCE TO BE BELOW THE ACTUAL VALUE, NOT REPORTING ALL ASSETS OWNED (CASH, STOCKS, DIVIDENDS, PROPERTY INCLUDING ESTATE PROPERTY, BANK ACCOUNTS, ETC.) PURCHASING CERTIFICATES OF DEPOSITS, AND PURCHASING EXORBITANT PRE-NEED FUNERAL CONTRACTS.

MN: OUTRIGHT GIFTING OF REAL AND PERSONAL PROPERTY, ALONG WITH PLANNING OF INELIGIBILITY PERIODS, IS USED MOST OFTEN. LIFE ESTATES ARE A COMMON VEHICLE FOR TRANSFERRING REAL PROPERTY. THE PURCHASE OF ANNUITIES AND ESTABLISHING TRUSTS ARE ALSO COMMON. NEW VEHICLES, SUCH AS THE FAMILY LIMITED PARTNERSHIP AND BUSINESS TRUSTS HAVE ALSO BEEN SEEN.

MS: TRANSFERRING ASSETS AND WAITING OUT THE PENALTY PERIOD OR SEEKING EXEMPTIONS FROM THE TRANSFER.

NV: QIT'S, SNT, ANNUITIES, SPOUSAL DIVISIONS, REVERSE MORTGAGES, TRANSFERRING EXEMPT RESOURCES.

NC: THE PURCHASE OF ANNUITIES IS BECOMING A VERY POPULAR METHOD FOR DIVESTING ASSETS. SPECIAL NEEDS TRUSTS ARE USED QUITE FREQUENTLY, BUT PRIMARILY THOSE ARE USED IN PERSONAL INJURY SETTLEMENTS.

ND: GIFTS OF ASSETS, PURCHASE OF ANNUITIES, FALSE STATEMENTS ABOUT ASSET TRANSFERS.

OH: THE MOST COMMONLY USED ARTIFICIAL IMPOVERISHMENT TECHNIQUES IN OHIO ARE TRANSFERRING THE HOME (WHILE PERSON IS STILL ALIVE), CREATING ANNUITIES, AND GIFTING MONEY TO KIDS. WE'RE SEEING A DECLINE IN THE USE OF LIFE ESTATES. WHILE SOME TECHNIQUES MAY NOT BE USED IN THE MAJORITY OF CASES, WHEN THEY ARE USED THEY INVOLVE LARGE SUMS OF MONEY. FOR EXAMPLE, CASH AND REAL ESTATE TRANSFERS SEEM TO OCCUR MORE OFTEN IN THE RANGE OF \$100,00 TO \$250,000. WE ARE DETECTING A GROWTH IN THE LEVEL OF AWARENESS AND SOPHISTICATION ABOUT HOW TO SHELTER ASSETS.

OR: IN OREGON, IT IS COMMON FOR A COUPLE WITH EXCESS RESOURCES TO PURCHASE AN ANNUITY WITH THE COMMUNITY SPOUSE AS THE ANNUITANT. THAT CAUSES THE ASSET TO BE COUNTED AS THE COMMUNITY SPOUSE'S INCOME RATHER THAN A RESOURCE AVAILABLE TO THE CLIENT. IT IS ALSO COMMON FOR COUPLES THAT CAN AFFORD THE LEGAL FEES, TO GET A SPOUSAL SUPPORT ORDER THAT INCREASES THE MMMNA SO THAT A HIGHER CSRA IS NEEDED TO GENERATE THE INCOME NEEDED BY THE COMMUNITY SPOUSE TO MEET LIVING EXPENSES.

SC: TRANSFERRING RESOURCES (INCLUDING RETIREMENT FUNDS) INTO ANNUITIES IN THE SPOUSE'S NAME AND CALLING THESE THE SPOUSE'S RETIREMENT FUNDS, WHICH WOULD BE EXEMPT BECAUSE WE ARE NOT COUNTING THE SPOUSE'S RETIREMENT FUNDS AS A RESOURCE TO THE SPOUSE. CREATING FAMILY LIMITED PARTNERSHIPS AND SAYING THAT APPLICANT CAN NOT SELL HIS/HER SHARES BECAUSE THERE IS NO MARKET.

TX: AGGRESSIVE TRANSFERS JUST UNDER THE MONTHLY PENALTY THRESHOLD. INTERSPOUSAL TRANSFERS AND THEN THE INELIGIBLE SPOUSE TRANSFERS ASSET.

UT: THE MOST COMMON PROBLEM IS THE PURCHASE OF ANNUITIES. WE HAVE NOT HAD A LARGE NUMBER OF CASES BUT THIS PRACTICE IS INCREASING. . . . THIS HAS NOT BEEN A PROBLEM IN THE PAST BUT I BELIEVE IT WILL BECOME A

PROBLEM IN THE FUTURE UNLESS WE ARE ABLE TO IMPLEMENT POLICY THAT CONTROLS ANNUITIES.

7. Are divestiture controls (such as transfer of assets restrictions), liens and estate recoveries politically sensitive issues in your state? Are there concerns about whether vulnerable seniors will fail to seek needed care if Medicaid is more restrictive? Please explain and provide examples.

NO: AL, AZ, DC, NV

YES: AR, CT, DE, GA, KY, LA, ME, MI, MS, MT, ND, OH, OR, SC, TX, UT

NO ANSWER OR DON'T KNOW: IN, MN, NC

NOTABLE COMMENTS:

LA: ESTATE RECOVERY IS A SENSITIVE SUBJECT. SOME SENIORS DO NOT WANT TO APPLY FOR MEDICAID, BECAUSE THEY DO NOT WANT YOU TO KNOW THEIR FINANCIAL SITUATION. AFTER HEARING ABOUT ESTATE RECOVERY, SOME NO LONGER WANT TO APPLY. SOME RECEIVE INACCURATE INFORMATION OR BASE THEIR SITUATION ON SOMEONE ELSE'S EXPERIENCE. OTHER BARRIERS INCLUDE: THEY DO NOT KNOW THE REQUIREMENTS, HEAR RUMORS ABOUT WHAT IS COUNTED OR HEAR THAT A LOT OF INFORMATION AND VERIFICATIONS ARE NEEDED, HAVE HEARD THAT MEDICAID DOESN'T PAY FOR ANYTHING, ETC.

ND: WHAT APPEARS TO BE POLITICALLY SENSITIVE IS ANY CONSTITUENT CONCERN THAT IS ADDRESSED TO A LEGISLATOR. THAT HAS PRODUCED EFFECTIVE OPPOSITION TO MEDICAID AGENCY EFFORTS TO SECURE LEGISLATION. . . .

OH: ESTATE RECOVERIES HAVE BEEN A SENSITIVE ISSUE, ERUPTING OCCASIONALLY AS AN ISSUE IN LOCAL PAPERS. HISTORICALLY, OHIO LEGISLATORS HAVE NOT BEEN ZEALOUS TO TAKE A HARD STANCE ON THE ISSUE AND ALIENATE CONSTITUENTS.

OR: THE ISSUES OF ARTIFICIAL IMPOVERISHMENT, LIENS AND ESTATE RECOVERY ARE POLITICALLY CHARGED ISSUES IN OREGON. . . . REGARDING LIENS AND ESTATE RECOVERY, HISTORICALLY, THE DEPARTMENT HAS BEEN RELUCTANT TO IMPLEMENT LIENS ON REAL PROPERTY BECAUSE OF THE POTENTIAL CHILLING EFFECT. THERE HAVE BEEN CASES WHERE CLIENTS, INFORMED OF THE ESTATE RECOVERY PROGRAM, ELECT NOT TO SEEK PUBLIC ASSISTANCE, BECAUSE THEY WANT TO "LEAVE SOMETHING FOR THEIR CHILDREN." THERE ARE CASES WHERE THE FACT PATTERN SUGGESTS THAT CHILDREN HAVE PERSUADED/COERCED THEIR PARENTS NOT TO APPLY FOR MEDICAID, BECAUSE THE CHILDREN EVIDENTLY FELT THEIR PARENTS REALLY

DID NOT NEED PUBLIC ASSISTANCE IF IT MEANT THE INHERITANCE WOULD BE DIMINISHED.

SC: THE ELDER BAR AND THE PROTECTION & ADVOCACY GROUPS IN OUR STATE LOBBY THE LEGISLATURE TO BLOCK EFFORTS TO STRENGTHEN DIVESTURE CONTROL MEASURES.

UT: ESTATE RECOVERY IS A SENSITIVE ISSUE. OVER THE PAST 20 YEARS THE ISSUES REGARDING ESTATE RECOVERY, LIENS AND THE POSSIBLE IMPACT ON SENIORS HAVE BEEN RAISED MANY TIMES. SEVERAL COMMITTEES AND TASK FORCES HAVE BEEN CONVENED TO DISCUSS THESE CONCERNS WITHOUT MUCH OUTCOME. DUE TO THE CONCERNS OF SENIOR ADVOCATES, THE UTAH STATE MEDICAID AGENCY HAS CHOSEN NOT TO IMPLEMENT TFERA LIENS OR LIENS OF RECORD AT THE TIME OF ELIGIBILITY. HOWEVER, THE CONCERNS REGARDING ESTATE RECOVERY HAVE BEEN COUNTERED WITH INFORMATION ABOUT THE ASSET DIVESTITURE AND ESTATE PLANNING INDUSTRY WHICH ACTIVELY ASSISTS MIDDLE AND HIGH INCOME SENIORS AND ADULT HEIRS TO SHELTER ASSETS AT THE EXPENSE OF THE TAXPAYERS. THAT ALONG WITH THE DRAIN OF THE MEDICAID PROGRAM ON THE STATE BUDGET SEEMS TO HAVE MINIMIZED THE POLITICAL SENSITIVITY OF ESTATE RECOVERY. IN ADDITION, THERE IS NO EMPIRICAL DATA WHICH SUGGESTS THAT SENIORS ARE NOT SEEKING MEDICAL ASSISTANCE DUE TO THE FEAR OF NOT BEING ABLE TO LEAVE THEIR ESTATE TO THEIR ADULT HEIRS. OF COURSE IN MANY CASES ADULT HEIRS HAVE ALREADY SUCCESSFULLY TRANSFERRED THE SENIORS ASSETS OUT OF SIGHT OF THE STATE SO ESTATE RECOVERY BECOMES A NON ISSUE.

8. Do you already have a Medicaid lien program? If yes, please describe its effectiveness, i.e. cost vs. revenue generated for the past three fiscal years. If no, do you intend to implement one? Why?

YES: AL, AZ (IMPLEMENTING), CT, DE, LA, MN, MT, NV, OH

NO: AR, DC, GA, KY, ME, MI, MS, NC, ND, OR, SC, TX, UT

NO ANSWER: IN

FOR DETAILS, PLEASE SEE THE MASTER DOCUMENT AT [HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) .

9. Do you have a Medicaid estate recovery program? If yes, what were your costs of recovery and total state and federal funds recovered for the past three fiscal years?

YES: AL, AZ, AR, CT, DC, DE, KY, LA, ME, MN, MS, MT, NC, NV, ND, OH, OR, SC, UT

NO: GA, MI, TX (LEGISLATION PASSED REQUIRING MER)

NO ANSWER: IN

**FOR DETAILS, PLEASE SEE THE MASTER DOCUMENT AT
[HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) .**

10. If Medicaid nursing home eligibility becomes harder to obtain and less desirable because of stricter eligibility rules and/or stronger estate recovery requirements, do citizens of your state have cost-effective alternatives, such as private-pay home and community-based care, assisted living facilities, home equity conversion (e.g. reverse mortgages) for supplemental income, and high quality private long-term care insurance for advanced planning? Please explain.

**FOR DETAILS, PLEASE SEE THE MASTER DOCUMENT AT
[HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) .**

11. Has Medicaid resident census (as compared to private-pay census) in your state's nursing homes increased in the past 10 years? If so, from what to what percent approximately? Is this change attributable to eligibility bracket creep and/or Medicaid estate planning? What has been the impact on (1) the state Medicaid budget and (2) nursing home reimbursement levels. Please explain.

AL: DECREASE FROM 71% TO 59%
AZ: UNCHANGED
AR: NA
CT: UNCHANGED
DC: INCREASE
DE: NA
GA: INCREASE FROM 75% IN 1996 TO 85% IN 2003
IN: DECREASE BY 12.23
KY: UNCHANGED
LA: DECREASE 12.07% FROM 1993 TO 2003
ME: DECREASE
MI: UNCHANGED
MN: INCREASE
MT: UNCHANGED
MS: UNCHANGED
NV: UNCHANGED
NC: UNCHANGED
ND: UNCHANGED
OH: DECREASE
OR: INCREASE FROM 60% TO 65%
SC: UNCHANGED
TX: UNCHANGED
UT: UNCHANGED

NA = NO ANSWER

**FOR DETAILS, PLEASE SEE THE MASTER DOCUMENT AT
[HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) .**

12. Is your state moving toward home and community-based services (HCBS) as a cost-effective substitute for nursing home placement? If so, how? How do you expect the availability of Medicaid-financed HCBS to affect (a) the number of Medicaid applications, (b) the popularity of Medicaid estate planning, and (c) the demand for private long-term care insurance?

**FOR DETAILS, PLEASE SEE THE MASTER DOCUMENT AT
[HTTP://WWW.CENTERLTC.ORG/SURVEY_RESPONSES.PDF](http://www.centerltc.org/survey_responses.pdf) .**

Appendix B: Respondents/Interviewees

John Barrette, President, Nebraska Tax Research Council, Inc.

Bryson Bartels, Legislative Coordinator, Nebraska Health and Human Services System (HHSS)

Dick Bauer, Executive Director, Midland Area Agency on Aging

Nancy Bettin, Social Services Supervisor, HHSS

Nancy Binder, Social Service Worker, Nebraska Health and Human Services System

John Bjornson, LTC Marketing Manager, Financial Brokerage, Inc.

Heath Boddy, Executive Director, Gold Crest Retirement Center

Mike Boden, Employee Benefits Administrator, State Personnel Office

Bruce Bohrer, Vice President, Governmental Affairs Council, Lincoln Chamber

Cec Brady, Deputy Medicaid Administrator, HHSS

John A. Carlson, Principal, SilverStone Group

Martha Carter, Analyst, Legislative Performance Audit Section

John Clark, Vice President for LTC, Mutual of Omaha

Connie L. Cooper, Executive Director, Northeast Nebraska Area Agency on Aging

Connie Cordell, Director Social Work & Donate Life Services, The Nebraska Medical Center

Dave Creal, Operation Coordinator, Better Health Services Inc.

Steve Curtiss, Director of Finance and Support (includes Medicaid), HHSS

David Cygan, Administrator of Medicaid Managed Care with overlap on TPL, HHSS

Nancy Daniel, Social Service Supervisor, Health and Human Services System

Doug Dexter, Assistant Attorney General, Nebraska

Houston Doan, Aging Services, Nebraska

Eric B. Dunning, Attorney, State of Nebraska Department of Insurance, Legal Division

*The Heartland Model for Long-Term Care Reform:
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Gayle Durfee, Social Service Worker, HHSS

Jon A. Edwards, Attorney at Law, Legislative Aide, Health and Human Services Committee

David Emerton, Marketing Consultant, Mutual Protective Insurance Company

Patrick L. Engel, (Senator), Chair, Executive Board of the Legislative Council

Lynne Fees, Attorney, Marks Clare and Reed

Mike Flair, Manager, Home Instead Senior Care

Emi Nyman Giles, Program Analyst, Lead, Finance & Support, Financial Services, Financial and Program Analysis, Health and Human Services System

Christine Good, Paralegal, Holthaus Law Offices

Ginger Goomis, FFP Manager, HHSS

Frederick H. Grossman, Franchise Owner, Home Instead Senior Care

Allen Hager, President, Right at Home

Kimberle Hall, Executive Director, Nebraska Association of Home and Community Health Agencies (NAHCHA)

Mike Harris, Deputy Administrator, Office of Economics and Family Support

Brian Haswell, Regional Vice President, Lincoln Benefit Life

Geri Hepp, Program Director, Alzheimer's Association

Lyle Hight, Administrator, Stanton Health Center

Sally Hinds, Medicaid Eligibility Program Specialist, HHSS

Roger R. Holthaus, Attorney at Law, Holthaus Law Offices

Liz Hruska, Program Analyst, Legislative Fiscal Office

Nan Hynes, Director of Case Management, Great Plains Regional Medical Center

Mark Intermill, State Director, AARP Nebraska

Mary Jo Iwan, Administrator, HHSS

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Gay Jeffries, Administrator, HHSS

Senator Jim Jensen, Chairman, Health and Human Services Committee

Paul Jensen, Director of Workers Discharge Planning, Bryan LGH Medical Center

Ron Jensen, Executive Director, Nebraska Association of Homes and Services for the Aging

Cindy Kadavy, Long-Term Care Ombudsman, HHSS

George Kahlandt, Administrator (Public Assistance Unit), HHSS

Gary Katelman, Broker, Senior Market Sales, Inc.

George Kilpatrick, Legal Counsel, Revenue Committee

Kim Kleine, Clinical Coordinator, Alegent Home Care

Liza Kryski, Reverse Mortgage Specialist, Burlington Credit Union

Senator David Landis, Chairman, Revenue Committee

Don Lawler, Assistant General Counsel, Mutual Protective

Bill Marienau, Legal Counsel, Banking, Commerce, and Insurance Committee, Nebraska
Legislature

Angie McClelland, Analyst, Legislative Performance Audit Section, Nebraska Legislature

Mike McCrory, Director of Personnel, State Personnel Division, Department of Administrative
Services

Dana McNeil, Program Specialist in Estate Recovery and Third Party Liability, HHSS

Bradley A. Meurrens, Public Policy Specialist, Nebraska Advocacy Services

Janet Mickelsen, Benefit Specialist, State Personnel Office

Glenn Miller, Product Management (LTC Division), Physicians Mutual

Tracy Miller, Medicaid Social Services Worker, HHSS

Dick Nelson, Director of Regulation and Licensure, HHSS

Darrold Nies, Administrator, Nemaha County G.S.C

*The Heartland Model for Long-Term Care Reform:
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Jan Nixon, Executive Director, The Meadows

Larry Ossowski, Executive Director, Blue Rivers Area Agency on Aging

Gerald Pankonin, Attorney, Finance and Support Department, HHSS

Susan Peters, RN, Executive Director, Memorial Health Center

Christine Peterson, Policy Secretary, HHSS

Roger Petrik, President, Rural Health Development, Inc.

Mark Quandahl, (Senator), Chair, Banking, Commerce, and Insurance Committee

Senator Ron Raikes, Chairman, Education Committee

Dr. Richard Raymond, Chief Medical Officer, HHSS

June Remington, Director, Aging Services

John E. Rink, Actuarial Assistant, State of Nebraska Department of Insurance Life/Health Division

Ron Ross, Director of Health and Human Services

Pat Samway, Director of Patients, Tri-County Hospital

Jeff Santema, Legal Counsel, Health and Human Services Committee

Cheryl Schmieding, Reverse Mortgage Specialist, Wells Fargo Home Mortgage

Gary B. Schneider, Attorney, BS&C

Joyce Schneider, Medicaid Eligibility Program Specialist, HHSS

Bob Seiffert, Medicaid Administrator, HHSS

Dale Shallenberger, Program Specialist, HHSS

Linda Shandera, Long Term Care Services Coordination Program Manager, HHSS

Melinda Smith, Program Assistant Public Policy Coordinator, Alzheimer's Association

Pat Snyder, Executive Director, Nebraska Health Care Association/Nebraska Assisted Living Association

*The Heartland Model for Long-Term Care Reform:
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Mary Steiner, Program Analysis and Research Administrator, HHSS

Daniel R. Stogsdill, Attorney, Cline Williams

Tim Stuart, Legislative Counsel-Government Affairs, Greater Omaha Chamber of Commerce

Jerry Sukup, Reverse Mortgage Specialist, Financial Freedom Senior Funding Corp.

Martin W. Swanson, Counsel, State of Nebraska Department of Insurance, Legal Division

Deborah Swearingen, Social Service Worker, Nebraska Health and Human Services System

Dr. James A. Thorson, Professor and Chairman, Department of Gerontology, University of Nebraska, Omaha

Galen Ullstrom, Government Affairs, Mutual of Omaha

Kris Valentin, Legislative Aid, Senator Ron Raikes

Michelle Vanarn, Home Health Director, Crete Area Medical Center

Denise A. Waibel-Kyceck, RN, MS, Director of Home Care Services, Good Samaritan Hospital

Victor L. Walker, Executive Director, Aging Office of Western Nebraska

Laurie Weber, Research Analyst for Senator Curt Bromm, Speaker of the Legislature

Senator Roger Wehrbein, Chairman, Appropriations Committee

Mary Wilson, Attorney and Staff Attorney for Lincoln Information for the Elderly and the Blue Rivers Area Agency on Aging

Appendix C: Project Contract

The following agreement setting out the terms of the Nebraska "Controlling Medicaid Long-Term Care Costs" study was signed by the parties thereto--Senator Jim Jensen and Senator L. Patrick Engle for the Nebraska Legislature and Stephen A. Moses, President for the Center for Long-Term Care Financing--in the first half September 2003. Work on the project began as scheduled on September 15, 2003 and concluded as scheduled on December 1, 2003 with the submission of this final report.

AGREEMENT

THIS AGREEMENT is made between the Nebraska Legislature and the Center for Long-Term Care Financing, a private, tax-exempt nonprofit corporation (Consultant). It is agreed by and between the parties as follows:

1. Section 10 of LB 407 (2003), in part, appropriates \$500,000 in FY 2004 to the Legislative Council from the Nebraska Health Care Cash Fund "for the purpose of ongoing health-related research and public policy development by the Health and Human Services Committee of the Legislature. Such funds may be used for, but shall not be limited to, hiring temporary legal research assistance, consulting and research contracts, and reimbursement for necessary and appropriate expenses incurred in connection with such research and policy development."

2. Consultant shall provide consulting services to the committee relating to study activities conducted by the committee pursuant to LB 407 (2003) as outlined in the attached addendum to this agreement.

3. In consideration of the matters described above, the Legislature shall pay Consultant pursuant to the attached addendum for consulting services provided by Consultant pursuant to this agreement and attached addendum.

4. Consultant agrees that it maintains a drug free workplace. Consultant further agrees that it does not discriminate against any employee or applicant for employment because of age, race, color, disability, religion, gender or national origin.

5. For all intents and purposes under this Agreement, Consultant is an independent contractor.

6. This agreement may be terminated by either party upon thirty days notice, and may be extended upon the mutual written agreement of both parties.

7. This instrument and the attached addendum contain the entire agreement between the parties, and no statements, promises, or inducements made by either party or agent of either party that are not contained in this written contract and attached addendum shall be valid or binding; this agreement may not be enlarged, modified, or altered except in writing signed by the parties and indorsed on this agreement.

*The Heartland Model for Long-Term Care Reform:
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IN WITNESS WHEREOF, the Nebraska Legislature and Consultant have caused this Agreement to be signed below.

Senator L. Patrick Engel, Chair
Executive Board of the Nebraska Legislature

Center for Long-Term Care Financing
Stephen A. Moses, President

Date

Consultant's Social Security Number or
Federal Identification Number

Senator Jim Jensen, Chair
Health and Human Services Committee

Date

Date

Addendum

Project Proposal: Controlling Medicaid Long-Term Care Costs

Submitted to Senator Jim Jensen, Chairman
Nebraska State Senate Health and Human Services Committee
by
Stephen A. Moses, President
Center for Long-Term Care Financing

I. Objective: Produce a step-by-step plan to save the State of Nebraska \$50 million per year in Medicaid nursing home expenditures while simultaneously assuring universal access to top quality long-term care for all citizens (rich and poor alike) across the spectrum from home and community-based to nursing home care.

II. Problem: Medicaid nursing home expenditures in Nebraska nearly doubled from \$138.0 million in 1991 to \$258.3 million in 2001. This rapid cost increase severely impairs the state's ability to maintain generous Medicaid nursing home eligibility criteria, to expand the home and community-based services often preferred by seniors, and to sustain adequate financing for other critical state services such as corrections, education, and highways.

III. Diagnosis: Generous Medicaid nursing home eligibility rules in Nebraska (and elsewhere), although well-intentioned and politically popular, have gradually converted a means-tested public assistance program (welfare) into an expensive, *de facto* long-term care entitlement program. Consequently, private out-of-pocket and insurance financing of home, community-based, and nursing home care have languished while Medicaid costs for these programs have skyrocketed. The public policy dilemma is to contain Medicaid long-term care spending in a politically sensitive way without increasing taxes or cutting benefits.

IV. Treatment: The solution to this quandary, proposed in a long series of reports by the US-DHHS Inspector General, the United States General Accounting Office, LTC, Incorporated, and the Center for Long-Term Care Financing is to retain generous Medicaid eligibility criteria while controlling asset transfers and shelters, enhancing estate recoveries, and encouraging private long-term care financing alternatives. The difficulty with this solution, however, is that it is complicated to achieve and it is often opposed by various long-term care interest groups. Therefore, a two-fold public policy intervention is needed: the Medicaid program must ensure (1) that every federal and state statutory, regulatory and administrative remedy is fully employed to target public assistance resources to the most needy while diverting more prosperous people to private financing options and (2) that every stakeholder in the long-term care financing issue understands the benefit to its constituency of implementing the necessary measures. These are the specific goals that this project would seek to achieve.

V. Work Plan: To achieve the objective and goals of this project, we propose the following activities:

A. Examine Medicaid nursing home eligibility criteria in Nebraska with attention to federal and state statutory, regulatory and policy guidelines. Thoroughly study and review all relevant state and federal statutes, regulations and policy manuals and compare them to eligibility policies in other states. Provide recommendations for state legislation, program policy changes and federal waivers to achieve a stronger and tighter asset control methodology.

B. Review the state's implementation of OBRA '93 (Omnibus Budget Reconciliation Act of 1993), HIPAA '96 (Health Insurance Portability and Accountability Act of 1996) and BBA '97 (Balanced Budget Act of 1997) authorities. Interview responsible state staff and study existing plans, proposed legislation, and policy options under consideration. Recommend ways that the State of Nebraska can take full advantage of this powerful federal legislation.

C. Appraise the status of Medicaid estate planning (the artificial impoverishment of frail seniors to qualify them for publicly financed nursing home benefits) throughout the state. Review the legal literature on Medicaid planning in Nebraska and interview influential elder law attorneys. Recommend measures to control Medicaid estate planning and to encourage attorneys, financial planners, accountants and other senior advisers to suggest private long-term care financing alternatives while their clients are young and healthy enough to afford and qualify for them.

D. Plan and conduct site visits to at least three local Medicaid nursing home eligibility local offices (urban, suburban, and rural). Interview supervisors and eligibility workers; review eligibility policies and procedures; examine a judgmental sample of Medicaid nursing home eligibility case records; compile examples of Medicaid estate planning techniques; explore the potential impact of possible alternative solutions on affected field staff; and obtain ideas and recommendations from front line workers.

E. Analyze Nebraska's lien and estate recovery strategy including statutory authorities, regulations, administrative policies, program activity, and collections. Interview key program staff; analyze procedures; examine the integration of front-end eligibility controls with back-end collection efforts; estimate maximum recovery potential; research best practices from other states and explore the possibility of applying them in Nebraska. Recommend initiatives to maximize non-tax revenue to the State of Nebraska from lien and estate recovery programs.

F. Study long-term care insurance regulation in Nebraska. Interview representatives of the State Insurance Commissioner's office; review laws, regulations and policies governing the content and sale of long-term care insurance products in the state; interview agents and brokers who market home health and nursing home insurance policies concerning the obstacles they face; compare policies and practices in Nebraska with other states; and analyze the chilling effect of easy Medicaid eligibility on the marketability of private insurance alternatives. Recommend statutory, regulatory and policy changes to enhance early planning for private long-term care insurance as an affordable, high quality alternative to reliance on Medicaid nursing home benefits by default.

G. Investigate the potential of home equity conversion (HEC) as a source of private financing for long-term care services and as an income supplement to help older Nebraskans to afford private insurance for long-term care. Identify sources of reverse annuity mortgages (RAMs) in Nebraska; interview representatives of banks and other financial institutions that offer RAMs; determine the current and potential utilization of home equity conversion as a source of financing for long-term care to relieve the burden on public programs; recommend ways to encourage the use of home equity conversion to help seniors obtain quality long-term care services in the private market.

H. Interview and brief key long-term care stakeholders: e.g., senior and consumer advocates; Governor's staff; key legislators and staff; proprietary and non-proprietary nursing home, assisted living and home health providers; long-term care insurers; Medicaid planners; taxpayer representatives; the Chamber of Commerce and other business interests; Medicaid management, line and legal staff; and any other group which the state believes would be appropriate. It is critical to meet with each group separately to avoid adversarial confrontations between groups in the early stages of discussion and to target each group's special interests. The purpose of these meetings is to discern the prevailing attitudes of the various interested parties, both public and private, in the long-term care area and to introduce them to the consensus strategy described in the Inspector General's reports, LTC, Incorporated's Florida, Montana, Wisconsin, Illinois, Maryland, South Dakota and New Jersey reports, and the Center for Long-Term Care Financing's policy studies. We will conduct approximately two-hour meetings with each interest group that has a stake in the long-term care financing issue. Presentations will include a summary of the problem, an historical perspective on how America and Nebraska got into the fiscal and political LTC predicament we are in, a summary of recommendations from the DHHS Inspector General, other government agencies, and the Center for Long-Term Care Financing on how to resolve the situation, and an explanation of why it is in the best interest of each stakeholder group to work cooperatively with the others on the proposal under consideration to the mutual benefit of all. We will interview the attendees at these meetings to ascertain their positions on key issues and to learn their opinion of and response to the ideas presented. Each attendee will receive an information pack of articles and reports on the topic similar to the one enclosed herewith. (Folder to be provided with hard copy of this proposal.)

I. Examine the overall social impact (upon the elderly population, families, etc.) from the transfer of resources and assets. We propose to explore every aspect of the potential ramifications for seniors of the transfer of assets and resources issue and to provide relevant recommendations on each. For example, what effect does Medicaid estate planning have on the state's ability to finance and the nursing homes' ability to provide access to quality long-term care? How serious is the nursing home liability and liability insurance crisis in Nebraska and what are the ramifications for public and private long-term care patients? Will closing Medicaid eligibility loopholes discourage vulnerable seniors from seeking needed care? Does the easy availability of Medicaid benefits discourage advance planning and purchase of private long-term care insurance products or continuing care retirement community contracts? To what extent are middle class people on Medicaid consuming state tax revenues needed to fund other public needs such as education, highways, and prisons? Are there ways to divert the middle class to other financing mechanisms while making Medicaid benefits more readily available to the poor than

ever before? We will address all of these questions and many more similar ones in the final report of this project.

J. Prepare and submit an interim report mid-way through the project summarizing current status, problems encountered, solutions proposed, work remaining, preliminary findings, etc.

K. Analyze all data; write the final report including the action plan implementation strategy; and submit twelve original bound copies to the state. Two sets of recommendations will be provided. One set will suggest measures the state of Nebraska can take under existing state statutory authorities. The other set will suggest measures the state could take with and through a CMS (Center for Medicare and Medicaid Services) waiver of federal requirements. The final report will be entirely substantive, clear and readable as evidenced by our previous work products, samples of which are available upon request. The goal is to prepare a document suitable for presentation to the State Legislature as a game plan to improve long-term care access and quality, benefit seniors, reduce Medicaid expenditures and enhance the fiscal responsibility of state government.

L. Subsequent to publication of the final report, the principal author will be available in Nebraska for up to one week at the Legislature's convenience to present state legislative testimony, advise on implementation strategy, conduct media briefings, present findings to key interest group representatives, and provide any additional follow-up work desired by the state.

M. The preceding proposal is based on the assumption that the state will provide a desk, phone, and meeting space during our site visits and will assist us in obtaining necessary documentation, contacting appropriate respondents, scheduling interviews, and making other arrangements essential to the successful completion of the project. We strongly recommend that a staff person representing the sponsor of this study accompany the researcher on site visits and attend all or most of the stakeholder briefings. This kind of shared responsibility has worked very well in previous projects with other states. We estimate the total state staff time necessary to perform these functions during the entire project to be approximately 80 to 120 person hours.

VI. Site Visits: We anticipate the need to spend approximately 10 to 15 work days in Nebraska during this project for the purpose of conducting interviews and briefings, visiting local eligibility offices, analyzing current policies and procedures, conducting legal research, etc. In addition, we have allowed and budgeted for a post-project visit of five days for follow-up, testimony, briefings, etc.

VII. Schedule: We recommend beginning this project by September 15, 2003 and completing it by December 1, 2003.

VIII. Deliverables: One interim status report of several pages and twelve copies of a formal, bound final report reflecting accomplishment of all of the commitments made within this proposal.

IX. Business Proposal: We propose to conduct the work described in this proposal for the following compensation to the Center for Long-Term Care Financing, a 501(c)(3) charitable nonprofit, nonpartisan organization:

Retainer: \$20,000 upon signing
Progress: \$20,000 upon presentation of interim report
Completion: \$40,000 upon submission of final report
Travel expenses: Included
Total: \$80,000

This bid covers all fees and charges by the contractor to the State of Nebraska incidental to this project.

X. Experience and Credentials: All substantive work related to this project will be performed by Stephen A. Moses, President of Center for Long-Term Care Financing. The Center's Executive Director Amy Marohn McDougall and other staff will assist Mr. Moses with planning, research, and logistics. No one other than Center for Long-Term Care Financing staff will participate in the conduct of this study unless arrangements are made and permission is given by the sponsor.

A. The Center for Long-Term Care Financing is a 501(c)(3) charitable, nonprofit, nonpartisan think tank and public policy organization. The Center's mission is to ensure access to quality long-term care for all Americans. The Center pursues this mission through a strategy of encouraging public policy that targets scarce government LTC resources to the truly needy and incentivizes all who are able to plan, save, invest or insure for long-term care.

B. As to the competence and bona fides of Stephen A. Moses, President of the Center for Long-Term Care Financing, to conduct this research, Mr. Moses served for nine years with the Health Care Financing Administration as a Medicaid State Representative. In this capacity, he conducted periodic reviews of Oregon's long-term care eligibility system, asset control methodologies, and estate recovery program; he directed a feasibility study of closing eligibility loopholes and implementing estate recoveries in Idaho; and he surveyed every Medicaid eligibility system, lien and estate recovery program in the country (*The Medicaid Estate Recovery Study*, Region 10, November 1985).

In 1987, Mr. Moses joined the Office of Inspector General of the U.S. Department of Health and Human Services where he was the national project director and author of another national study of Medicaid nursing home eligibility, Medicaid estate planning, and asset and resource divestiture problems titled *Medicaid Estate Recoveries*, June 1988. He also directed and authored *Transfer of Assets in the Medicaid Program: A Case Study in Washington State*, May 1989 for the Office of Inspector General. Both of these projects delved deeply into all of the topics proposed for review in Nebraska. Mr. Moses advised the General Accounting Office

on all aspects of its study titled *Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs*, March 1989. He briefed then-incumbent Secretary Otis Bowen of the US-DHHS and Administrator William Roper of HCFA on the growing national problem of Medicaid asset/resource divestiture and the need for Medicaid estate recoveries and he wrote the Inspector General's contribution to the report to Congress on these subjects that was mandated by the Medicare Catastrophic Coverage Act of 1988 (*Medicaid Estate Recoveries: A Management Advisory Report*, December 1988.)

Since leaving federal service in 1989, Mr. Moses has published over 100 articles on Medicaid estate planning, nursing home eligibility, transfer of assets, liens and estate recoveries, and long-term care service delivery, financing and policy; he has consulted on these subjects in most U.S. states and spoken at innumerable national conferences. He has testified before over half of America's state legislatures. As Director of Research for LTC, Inc., Mr. Moses directed and authored studies on Medicaid nursing home eligibility, asset and resource transferring techniques, methods to control divestiture, estate recoveries, and how to implement OBRA '93 in numerous states, e.g.: *Medicaid Estate Recoveries in Massachusetts: How to Increase Non-Tax Revenue and Program Fairness*, December 1990; *The Senior Financial Security Program: A Plan for Long-Term Care Reform in Wisconsin*, June 1992; *Medicaid Estate Planning in Kentucky: How to Identify, Measure and Eliminate Legal Excesses*, March 29, 1993; *Long-Term Care in Montana: A Blueprint for Cost-Effective Reform*, September 23, 1993; *The Florida Fulcrum: A Cost-Saving Strategy to Pay for Long-Term Care*, April 21, 1994; *The Magic Bullet: How to Pay for Universal Long-Term Care, A Case Study in Illinois*, February 1, 1995; *The Long-Term Care Financing Crisis: Danger or Opportunity? A Case Study in Maryland*, September 15, 1995; *The Heartland Manifesto: How to Finance Long-Term Care for Middle America*, August 1, 1996; *The Jersey Share: How to Pay for Long-Term Care with Less Federal Money*, March 31, 1997. Of closely related significance is *Medicaid Loopholes: A Statutory Analysis with Recommendations*, which Mr. Moses presented to the minority staff of the United States Senate Committee on Finance in 1991 and *Medicaid Estate Planning: An Analysis of GAO's Massachusetts Report and Senate/House Conference Language*, presented to The United States Senate Committee on Finance and Special Committee on Aging, July 30, 1993. Most of these reports and publications are available for review upon request.

Since founding the Center for Long-Term Care Financing in 1998, Mr. Moses has continued to speak, write and publish on long-term care financing issues. The Center for Long-Term Care Financing's website at <http://www.centerltc.org/> contains many of his speeches, published articles, and reports. The Center's three major public policy reports are available in .pdf format on the website. These include *LTC Choice: A Simple, Cost-Free Solution to the Long-Term Care Financing Puzzle* (1998), *The Myth of Unaffordability: How Most Americans Should, Could and Would Buy Private Long-Term Care Insurance* (1999), and *The LTC Triathlon: Long-Term Care's Race for Survival* (2000). A biographical sketch of Stephen Moses is attached.

XI. References: The following persons may be contacted concerning the projects referenced in the project proposal:

1. New Jersey Project Coordinator: Susan Reinhard, Deputy Commissioner, Department of Health & Senior Services, John Fitch Plaza, CN-360, Trenton, NJ, 08625-0001, 609-292-7874.

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2. South Dakota Project Coordinator: Richard J. Reding, Executive Director, South Dakota Health Care Association, 804 N. Western Ave., Sioux Falls, SD, 57104, 605-339-2071.
3. Maryland Project Coordinator: Joe Coble, Director of Legislative and Government Relations, Health Facilities Association of Maryland, 229 Hanover St., Annapolis, MD, 21401, 410-269-1390.
4. Illinois Contract Officer: Jan Boone, Assistant Bureau Chief, Bureau of Long-Term Care, Illinois Department of Public Aid, Third Floor, 201 south Grand Avenue East, Springfield, Illinois, 62763, 217-524-7211.
5. Florida Contract Officer: Susan Ahrendt, Medical Health Care Program Analyst, Agency for Health Care Administration, Office of Medicaid Program Analysis, 1317 Winewood Blvd., Building 6, Room 235, Tallahassee, FL, 32301, 904-488-9350.
6. Montana Contract Officer: Terry Frisch, TPL Manager, Department of Social and Rehabilitation Services, 111 North Sanders Street, Box 4210, Helena, Montana, 59604, 406-444-4162.
7. Wisconsin State Contact: Gene Kussart, Executive Assistant, Department of Health and Social Services, P.O. 7850, 650 One West Wilson St., Madison, WI, 53707, 608-266-9622.
8. Inspector General contact: Michael Mangano, Principal Deputy Inspector General, Office of Inspector General, Room 5246 Cohen Building, 330 Independence Ave., S.W., Washington, DC, 20201, 202-619-3146.
9. U.S. Senate Contact: Roy Ramthun, Professional Staff Member, Senate Finance Committee, 203 Hart Building, Washington, DC, 20510, 202-224-5315.
10. Massachusetts State Contact: John Robertson, Acting Deputy Associate Commissioner, Medical Assistance, Essex Station, P.O. Box 68, Boston, MA, 02112, 617-348-5375.

Appendix D: The Blind Men and the Elephant

The Blind Men and the Elephant by John Godfrey Saxe. American poet John Godfrey Saxe (1816-1887) based the following poem on a fable which was told in India many years ago.

It was six men of Indostan
To learning much inclined,
Who went to see the Elephant
(Though all of them were blind),
That each by observation
Might satisfy his mind

The First approached the Elephant,
And happening to fall
Against his broad and sturdy side,
At once began to bawl:
"God bless me! but the Elephant
Is very like a wall!"

The Second, feeling of the tusk,
Cried, "Ho! what have we here
So very round and smooth and sharp?
To me 'tis mighty clear
This wonder of an Elephant
Is very like a spear!"

The Third approached the animal,
And happening to take
The squirming trunk within his hands,
Thus boldly up and spake:
"I see," quoth he, "the Elephant
Is very like a snake!"

The Fourth reached out an eager hand,
And felt about the knee.
"What most this wondrous beast is like
Is mighty plain," quoth he;
" 'Tis clear enough the Elephant
Is very like a tree!"

The Fifth, who chanced to touch the ear,
Said: "E'en the blindest man
Can tell what this resembles most;
Deny the fact who can
This marvel of an Elephant
Is very like a fan!"

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The Sixth no sooner had begun
About the beast to grope,
Than, seizing on the swinging tail
That fell within his scope,
"I see," quoth he, "the Elephant
Is very like a rope!"

And so these men of Indostan
Disputed loud and long,
Each in his own opinion
Exceeding stiff and strong,
Though each was partly in the right,
And all were in the wrong!

Moral:
So oft in theologic wars,
The disputants, I ween,
Rail on in utter ignorance
Of what each other mean,
And prate about an Elephant
Not one of them has seen!

Source: <http://www.wordfocus.com/word-act-blindmen.html>