

A man and a woman are lying in a brown wicker hammock, suspended by ropes. They are positioned over a deep, dark canyon with a river at the bottom. The sky is blue with light clouds. The man is on the left, wearing a tan shirt, and the woman is on the right, wearing a white top. They both appear relaxed and are looking towards the right.

Medi-Cal Long-Term Care:

Safety Net or Hammock?

Stephen A. Moses

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Medi-Cal Long-Term Care: Safety Net or Hammock?

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

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Table of Contents

Acknowledgements 6

Preface 7

Executive Summary..... 9

Introduction 13

Rebalancing..... 17

Medi-Cal LTC Eligibility 19

Medi-Cal Planning 22

OBRA '93 and DRA '05 25

Medi-Cal's Impact on LTC Providers 28

LTC Financing Sources that Could Relieve the Pressure on Medi-Cal..... 31

The CLASS Act..... 36

Conclusion..... 38

General Recommendations..... 39

Specific Recommendations 41

Bibliography..... 44

Interviewees 49

About the Author 51

Endnotes..... 52

Statement of Research Quality..... 64

About PRI..... 65

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Preface

This report is the product of a collaboration between the Pacific Research Institute (www.pacificresearch.org) of San Francisco and Sacramento, California, and the Center for Long-Term Care Reform of Seattle, Washington (www.centerltc.com).

Stephen A. Moses, president of the Center, conducted the research for this project (with assistance from Lingxiao Ou, a PRI summer intern) and wrote the report. John R. Graham, PRI's Director of Health Care Studies, and another scholar reviewed the manuscript and made comments.

The subject of long-term care (LTC) service delivery and financing, especially as it involves Medicaid eligibility, is complicated and often esoteric. I have attempted to keep this report as simple and straightforward as possible. But much of what you read herein will contradict widely held beliefs about the subject. Documentation, including citation to federal Medicaid rules, is extensive. But readers, including media, may contact the author for clarification. See page 51 for contact information.

California's Medi-Cal system denied us access to staff for this project. Staff shortages, extraordinary workloads, and three-day monthly furloughs were the reasons given. We therefore had to rely on information garnered from documentary research and interviews with interest group representatives. Because we were unable to get critical questions answered by state staff, we have left a number of questions and details open-ended with the hope that future research can fill in the gaps.

We firmly believe there are ways to operate California's Medi-Cal long-term care program that make more sense, that cost less in public funds, and that will provide better results for the state's neediest citizens. We hope this report provides insights and suggestions that will facilitate the achievement of those objectives.

Executive Summary

Long-term care is very expensive, whether provided in a nursing home, an assisted living facility, or in someone's home.

Medi-Cal pays for most professional long-term care in California. It covers 65 percent of nursing home residents and ranks third in the United States for coverage of home and community-based services.

The cost is already huge—\$3.8 billion for nursing homes and \$6.5 billion for home health and personal care in 2008—and is likely to increase rapidly because of the state's aging population.

The ability of California's economy to support a large and growing publicly financed LTC system is doubtful, yet advocates and courts consistently stymie program cutbacks.

Efforts to save money by "rebalancing" from institutional to home care have made Medi-Cal services more attractive and increased caseloads without controlling costs.

Constantly expanding Medi-Cal LTC benefits could cause a financial catastrophe. The path to a better approach lies through understanding why most Californians end up on Medi-Cal when they need LTC.

Conventional wisdom says that Medi-Cal LTC eligibility requires poverty-level income and very low assets. But the truth is that most middle-class people qualify easily for the program. So can the affluent with help from "Medi-Cal planners."

This report explains how easy and elastic Medi-Cal eligibility rules desensitize the public to LTC risk and cost, resulting in a false sense of security and entitlement.

Medi-Cal not only guarantees generous LTC eligibility, it has failed to implement important restrictions on financial eligibility mandated by federal laws in 1993 and 2005.

Californians' excessive dependency on Medi-Cal, with its inadequate and uncertain reimbursements, has devastated LTC providers at all levels.

Nursing homes struggle to serve higher acuity (sicker), less profitable residents; assisted living facilities have too few private payers but cannot afford to accept meager Medi-Cal reimbursements. Low-cost home care and adult day health care providers were the first and most severely cut by Medi-Cal.

Easy access for most Californians to Medi-Cal-financed LTC has distorted the service delivery system, causing an institutional bias historically and crowding out a privately financed market for home and community-based services today.

Medi-Cal's near monopsony (single-buyer market) in LTC financing has desensitized the public to LTC risk and cost, causing most Californians to ignore LTC planning until paying privately for care is prohibitively expensive or less desirable than relying on public assistance.

Consequently, the four primary alternative private LTC financing sources that could relieve financial pressure on Medi-Cal—personal asset spend-down, estate recovery, home equity conversion, and LTC insurance—remain largely untapped.

The CLASS Act, a new voluntary LTC financing program created by “health reform,” aka Obamacare, gives some of our interviewees hope but leaves most experts convinced it will quickly become insolvent due to low participation, adverse selection, moral hazard, and unlimited lifetime benefits.

California's Medi-Cal LTC safety net provides quality care for too few and a publicly funded long-term care “hammock” for too many. The system is financially unsustainable and ethically questionable.

A better approach is to remove the counterproductive incentives in Medi-Cal that have trapped generations on taxpayer-financed LTC.

The solution is to target Medi-Cal to the needy and privately uninsurable. Medi-Cal should not remain free “inheritance insurance” for the baby-boom generation at the expense of taxpayers, the poor, and the disabled. Fewer Medi-Cal dependents and more private payers would encourage a vibrant private-pay home- and community-based services infrastructure with a strong reverse mortgage and private LTC insurance market to help pay for it.

Unfortunately, federally mandated easy eligibility, extravagant supplemental federal matching funds, and “maintenance of effort” rules have made fixing Medi-Cal in this way difficult, if not impossible.

Dropping out of the federal program may be an option. Dennis Smith, the official who ran Medicaid during the Bush administration believes California could actually save \$133 billion by dropping out of Medi-Cal, of which \$7 billion would come from reducing LTC spending 10 percent over the next seven years.

With or without participating in Medicaid, California should:

- Clearly establish the principle that long-term care is a personal responsibility, not a social “right.”
- Conduct a comprehensive review of the current LTC service delivery and financing system to identify and eliminate policies that encourage public dependency.
- Incentivize the middle class and affluent to plan early and save, invest, or insure for LTC.
- Reduce the number of expensive Medi-Cal/Medicare “dual eligibles” in the future by diverting more Californians to private LTC financing alternatives while they are still young enough, healthy enough, and affluent enough to save, invest, or insure for LTC.

By applying these principles, long-term care service delivery and financing in California can grow private markets, create jobs, and generate tax revenues in home care, assisted living, adult day health, home equity conversion and long-term care insurance. Long-term care services can also do a better job for genuinely needy people who depend legitimately on a radically smaller social LTC safety net.

Such an approach can save taxpayers \$375 million per year by more aggressively enforcing stricter LTC eligibility rules allowed by current federal law; \$131 million per year by maximizing Medi-Cal estate recoveries; and \$1.25 billion per year by going beyond current federal statutory authorities either with a waiver or by dropping Medicaid altogether.

Introduction

The National Problem: Medicaid is a means-tested public assistance program, i.e., welfare. Yet Medicaid is the principal funding source for long-term care (LTC) throughout the United States, not only for the poor, but for most Americans. Although LTC users are only 7 percent of the Medicaid population, they account for more than half of the program's costs nationally. The only way Medicaid can survive as a long-term-care safety net for the poor is if more prosperous people plan responsibly and pay privately for their own long-term care. But Medicaid crowds out most private LTC financing alternatives such as home equity conversion and insurance. The trend toward greater and greater dependency on welfare-financed nursing home care is reversible. It will be reversed by responsible public policy or by default as costs skyrocket and public resources dwindle with the aging of the baby boomers.

The State Problem: California spent \$39 billion on Medi-Cal in 2008, of which \$12.5 billion (32.1 percent) were LTC expenditures, including \$3.8 billion for nursing homes and \$6.5 billion for home health and personal care.¹ California's age-85-plus population, the cohort most likely to require LTC, was 585,000 or 1.6 percent in 2007, but is expected to be 1,159,000 and 2.5 percent in 2030, a 98 percent increase.² Only 9.1 percent of Medi-Cal enrollees are elderly and 9.2 percent are disabled, compared to 10.2 percent and 15.1 percent, respectively, for the United States.³ Yet the elderly account for 27.1 percent of Medi-Cal spending (\$9 billion) and the disabled, 41.8 percent (\$13.9 billion). Medi-Cal is the primary payer for 65 percent of the state's nursing home residents. Another 13 percent rely primarily on Medicare.⁴

Medicaid and Medicare also pay for most home health care, 75 percent nationally. Eleven of every 1,000 Californians receive home- and community-based services from Medi-Cal, the third-highest rate in the United States. Our best estimate is that only 5.4 percent of California's 50-plus citizens own LTC insurance. Very few use home equity to fund LTC. Thus, financing Medi-Cal LTC is a large and growing strain on California's budget. Private LTC financing is minimal and shows few signs of increasing. Demographic and fiscal pressures will exacerbate these problems. Yet federal law and regulations inhibit some effective corrective actions California might take, such as tightening

Medicaid crowds out most private LTC financing alternatives such as home equity conversion and insurance.

loose eligibility rules, and encourage others, such as “rebalancing” from institutional to home care, which may increase utilization and costs.

Background: Long-term care (LTC) is custodial assistance or skilled medical attention that people require who are unable to take care of themselves fully for an extended period of time.

LTC is very expensive, wherever provided.⁵ In California, nursing home care costs \$256 per day for a private room and \$209 for a semi-private room on average; assisted living, \$2,576 per month; home care, \$25 per hour for an aide or \$91 per hour for a licensed practical nurse; and adult day health, \$80 per day.⁶

The Golden State provides and pays for most LTC through Medi-Cal, a state/federal program called Medicaid elsewhere.⁷ Medi-Cal is very expensive, especially its LTC component. Medi-Cal expenditures increased from \$9.9 billion in 2003-04 to \$14 billion in 2007-08 but eased off to \$10.9 billion in 2009-10⁸ because of fiscal pressures caused by the economic downturn.

At 19.7 percent of the state budget, Medi-Cal dwarfs other state priorities such as higher education (8.4 percent), public assistance (5.1 percent), corrections (5 percent) and transportation (5.8 percent). Only elementary and secondary education (24.2 percent) and “all other” programs (31.7 percent) cost more.⁹

Medi-Cal is the main source of health care coverage for 6.5 million people—more than one in six Californians.¹⁰ Total Medi-Cal LTC expenditures are difficult to pin down precisely because they fall under several different agencies,¹¹ but every component increased steadily over many years and would probably have continued to do so except for the financial crisis.

Financing Medi-Cal LTC is a large and growing strain on California's budget.

Medi-Cal spending for skilled nursing facilities rose from \$3.1 billion in fiscal year (FY) 2004 to \$3.9 billion in FY 2009;¹² home care (the In-Home Supportive Services Program or IHSS) increased from \$1.1 billion in 2003-04 to \$1.7 billion in 2007-08, but dropped to \$700 million in 2010-11;¹³ and adult day health care grew from \$370 million in 2004-05 to peak at \$418 million in 2006-07, falling back to \$351 million for 2010-11.¹⁴

Medi-Cal LTC expenditures are heavily skewed toward a relatively small number of recipients. The California HealthCare Foundation (CHCF) said in 2006: “Seniors and adults with disabilities account for one-fourth of enrollees, but nearly two-thirds of Medi-Cal expenditures.”¹⁵

In a 2010 report, CHCF elaborated: “High-cost beneficiaries tend to have continuous Medi-Cal coverage and incur high claims for at least three years. . . . Nearly half of high-cost Medi-Cal beneficiaries have Medicare coverage. Long-term care is a primary cost driver for high-cost Medi-Cal beneficiaries with Medicare coverage . . .”¹⁶

In other words, elderly people dually eligible for Medi-Cal and Medicare account disproportionately for large and growing program costs. No solution to the LTC financing problem is possible without addressing the “dual-eligibles” issue.

The federal government temporarily provides 62 percent of funding for Medi-Cal, up from the usual 50 percent.²⁰ Despite this large increase in federal matching funds, the governor, the legislature and the Department of Health Care Services, which administers the program, have found Medi-Cal LTC difficult to finance.

Dramatic measures to reduce the cost of Medi-Cal LTC, such as ending or cutting the IHSS and Adult Day Health Care (ADHC) programs, were stymied by the courts.²¹

Longer term efforts to constrain Medi-Cal LTC expenditures such as “rebalancing” from expensive nursing facility care to ostensibly cheaper home care—although widely supported by academics, public officials, legislators, and senior advocates—have neither reduced nor significantly curtailed the growth of total LTC costs.²²

The future does not bode well for Medi-Cal’s ability to finance LTC. “In 2007, more than a million Californians used long term care (LTC) services, including institutional and home- and community-based services (HCBS),” notes the California HealthCare Foundation. “That number is expected to skyrocket as the number of Californians 85 and older and working-age individuals with disabilities increases.”²³

California has a large and rapidly growing elderly population.²⁴ People over the age of 85, the group most likely to need expensive LTC due to chronic illness or frailty, are expected to increase from 628,000 to 2.9 million by 2050, a dramatic 364 percent increase.²⁵ California’s ability to sustain Medi-Cal LTC services, much less increase them to meet future needs, is seriously doubtful.

Dual Eligibles

Dual eligibles are heavy users of long-term care and acute care services not covered by Medicare. And Medi-Cal pays for their Medicare premiums and cost-sharing, too.

Dual eligibles are 13 percent of Medi-Cal recipients but account for 47 percent of Medi-Cal spending, which came to \$14.8 billion in 2005.¹⁷

Seniors and adults with disabilities, also heavy users of long-term care services, account for one-fourth of enrollees, but nearly two-thirds of Medi-Cal expenditures.¹⁸

Thus, the heaviest users of LTC, Medi-Cal’s most expensive benefit—dual eligibles and the aged, blind, and disabled (ABD)—consume a disproportionate share of the program’s total resources.

Therefore, every actual or potential dual eligible, ABD or LTC recipient diverted from Medicaid dependency will result in a disproportionate savings to the Medicaid program.

Conclusion: Prevent Medicaid dependency for even a small number of these heavy LTC users and the savings will be extraordinarily high.

Recommendation: Divert as many Californians as possible toward early planning to save, invest, and insure for long-term care expenses so they do not become dual eligibles in their senescence.¹⁹

The state has a \$19 billion budget shortfall as of this writing,²⁶ which “[l]egislative leaders are proposing to close . . . with creative accounting strategies that would delay many payments until the next fiscal year.”²⁷ The state suffers from “an unemployment rate of 12.3 percent (third-highest in the nation) and a business environment that is dominated by taxes, regulations, and lawsuits”²⁸ More waves of red ink are likely because of its weak economy, ranked 46th in the nation.²⁹

California’s ability to sustain Medi-Cal LTC services, much less increase them to meet future needs, is seriously doubtful.

California has set aside only \$3 million to cover its \$62 billion, long-term liability for retiree health care and other benefits, leading the Pew Center on the States to conclude, “In the face of California’s fiscal crisis, addressing this bill coming due will be a daunting challenge.”³⁰

A new October 2010 study re-estimates California’s pension obligations and underfunded retiree health benefits: “The total of these actuarial obligations thus reaches \$378.8 billion. . . . a staggering figure . . . more than five times the existing state debt.”³¹

According to the U.S. Chamber of Commerce: “One has to think all the way back to the early 1980s—nearly 30 years ago—to find the state in as big a mess as it is now.”³²

What is wrong? How did Medi-Cal LTC get into such deep trouble? What must be done to fix the problems and improve LTC services and financing? These are the questions this report will address.

The problems facing Medi-Cal LTC are many, complicated, and inter-related. We will address them one at a time first, then show how they relate to and aggravate each other, and finally suggest a comprehensive solution.

Rebalancing

Medi-Cal LTC pays predominantly for home and community-based services (HCBS) rather than institutional or skilled nursing facility (SNF) care, covering 80 percent of recipients in the home and community compared to the national average of 62 percent.³³

The dollars break out similarly in favor of HCBS according to a 2009 book-length study: “For older adults and adults with physical disabilities, California was ranked 5th nationally in the percentage of HCBS spending with 48 percent on institutional care and 52 percent on HCBS in 2007.”³⁴ But that was not always true.

The federal Medicaid program started in 1965. It paid exclusively for long-term care in nursing homes until 1981, when Congress authorized HCBS waivers. Thus most state Medicaid programs, including California’s, funded LTC predominantly in nursing homes for decades. It was not until fiscal year 2004 that California tipped the balance, paying more for HCBS than SNF care.³⁵

The argument in favor of HCBS, made strenuously by many academic and policy experts, is that taking care of frail or chronically ill elders at home is much cheaper than in a nursing home. Therefore, rebalancing from SNF services to HCBS should save the state money while giving people more of what they want (home care) and less of what they would rather avoid (nursing home care).

But is that true?³⁶ Will Medi-Cal’s expansion of HCBS and reduction of SNF services really save the state money over time? Will it improve accessibility and quality of the kind of care people prefer?

Intuitively, it would seem so. SNF services are expensive and HCBS seemingly much less so. Surely, Medi-Cal can serve more people in their homes and communities for less money and with better outcomes than in nursing facilities. But the reality is more complicated. Decades of empirical studies

The evidence is in about potential cost savings from rebalancing

“When compared to an elderly population for whom traditionally available care is offered, recipients of expanded community-based services do not use significantly fewer days of nursing home care.” (GAO, 1982)³⁸

“An increasingly large number of studies, including the results of a national channeling demonstration program, have shown that non-institutional services typically do not substitute for nursing home care, but, rather, represent additional services most often to new populations.” (Holahan and Cohen, 1986)³⁹

“Although community-based LTC programs proved beneficial to both clients and informal caregivers in the LTC demonstrations, they did not prove budget neutral or cost effective.” (Manton, 1991)⁴⁰

“The Channeling demonstration . . . found that, while community-care models were often welcome by recipients and their caregivers, they led to overall increases in public spending for long-term care.” (Caro, 2003)⁴¹

“The research evidence that changing the delivery system will produce substantial Medicaid savings is not strong, but it is a premise strongly held by many state officials and consumer advocates.” (Wiener and Anderson, 2009)⁴²

show HCBS delay but do not replace institutionalization. Year after year, combined costs for SNF care and HCBS continue to rise in spite of, or perhaps because of, rebalancing.³⁷

Tough questions arise. Would people who receive HCBS have otherwise entered SNFs? Do they reduce costs or merely add recipients? With housing costs so high in California, isn't losing the institutional economy of scale very expensive? How can providing home care services people want instead of nursing home care they dread save money?

The path to a more promising solution lies through a better understanding of why and how most Californians who need long-term care end up on Medi-Cal.

In-Home Supportive Services is California's largest Medi-Cal HCBS program. IHSS has lenient functional eligibility requirements and allows Medi-Cal recipients to hire and pay their own caregivers, including family members. One study found that this policy helps "prevent further functional decline," "addresses tight labor pools and supports family caregiving."⁴³ The same study claimed that HCBS programs are cost-effective.⁴⁴

Unfortunately, this policy of easy access to IHSS and paying family members for care drives up program participation and induces population-wide complacency about LTC risk. It replaces free private care—valued in 2007 at \$48 billion or five times Medi-Cal LTC spending and 9.1 times Medi-Cal HCBS spending⁴⁵—with paid services at enormous public cost.

California's Legislative Analyst concluded this year: "After accounting for both costs and savings to the state and counties, IHSS probably results in net costs. This is because the savings (in the form of avoided nursing home costs) are probably more than offset by the costs (to provide IHSS and related services) for those recipients who would not be institutionalized in the absence of the program."⁴⁶

Devotees of the belief that rebalancing can save money and improve Medicaid-financed LTC cling to hope while disregarding hard reality. The only study supporting their position "found that states with well-established HCBS programs had much lower rates of spending growth compared to those with low HCBS spending" but only after "a lag of several years before institutional spending appeared to decline."⁴⁷

California has already stopped throwing good money after bad on this wishful thinking as evidenced by the fact that HCBS were the services cut first and most in response to plummeting revenues since 2008.

The state's efforts to save Medi-Cal money by rebalancing from nursing home care to home and community-based care have clearly failed. But the solution cannot be a return to the institutional bias that plagued the program in years past. Not only would covering more people in nursing homes again cost more money, it isn't possible anyway because low-acuity patients no longer qualify medically for SNF care under Medi-Cal rules.

The path to a more promising solution lies through a better understanding of why and how most Californians who need long-term care end up on Medi-Cal. Once that is understood, we can explore ways to prevent most people from becoming dependent on public assistance for long-term care.

Medi-Cal LTC Eligibility

Income Eligibility

Medi-Cal is a means-tested public assistance program. In a word . . . welfare. Ostensibly, Medi-Cal LTC eligibility requires poverty-level income and very low assets (\$2,000). That's what the popular media always say, often echoed by academic coverage. The reality is very different and much more complicated. Income is rarely an obstacle to qualifying for Medi-Cal LTC benefits.

California has a “medically needy” or “share of cost” eligibility system, which means Medi-Cal deducts medical expenses, including the cost of nursing home care, from applicants' incomes before deciding if they are poor enough to qualify.⁴⁸ “[S]hare of cost Medi-Cal provides benefits for individuals and families with incomes too high to qualify for cash assistance, but too low to cover their health care costs.”⁴⁹

Thus, to qualify for Medi-Cal LTC services, people don't need to be low-income at the outset. They only need to have a cash flow problem—too little personal income to cover all their medical and LTC expenses. In fact, they don't even have to pay first: “[R]ecipients may use old, unpaid medical bills for which the beneficiary is still legally responsible to reduce the monthly Medi-Cal share of cost.”⁵⁰

In 2007, Medi-Cal had 75,594 share-of-cost recipients, of which 70 percent were medically needy elderly or disabled in LTC facilities costing on average \$34,000 per year, “nearly eight times the average expenditures for Medi-Cal beneficiaries overall.”⁵¹

Asset Eligibility

But what about assets? Individuals with more than \$2,000 in cash—or any other asset easily convertible to cash—are ineligible. Surely that rule forces people to spend down their savings catastrophically before they qualify for Medi-Cal assistance.

Not so. Federal and state Medicaid rules do not require people to spend down savings for care. As long as they do not give away assets for less than fair market value and for the purpose of qualifying for Medi-Cal, they may purchase anything for value they like.

For example, neither purchasing a world cruise nor buying exempt assets such as home furnishings or a better car is disqualifying, and such methods to qualify for Medi-Cal are often recommended. See the examples of such recommendations in the section below on “Medi-Cal Planning.”

Furthermore, Medi-Cal applicants or recipients (ARs) may retain practically unlimited exempt assets including:⁵²

Medi-Cal applicants or recipients (ARs) may retain practically unlimited exempt assets.

The Renoir Loophole

The Social Security Administration (SSA) runs the Supplemental Security Income program (SSI). SSI is federally administered cash assistance to the aged, blind and disabled. SSI is important to Medicaid because in most states, most of the time, anyone eligible for SSI is eligible for Medicaid, including Medicaid's most expensive long-term care benefits. Thus, the easier SSI is to obtain, the easier it is for people to qualify for Medicaid.

SSI used to place a dollar limit on the value of "household goods and personal effects" that SSI recipients could own without affecting their eligibility for the program's benefits. SSI also limited the value of an exempt automobile under certain circumstances. Effective March 9, 2005, however, those rules changed. Now there is no limit on the value of household goods, personal effects, or an automobile that SSI recipients (and hence Medi-Cal recipients) can own without affecting their eligibility for these public welfare programs.

This rule change breathed new life into the "Two Mercedes Rule" and "Renoir Loophole," which one author described this way: ". . . if the individual happens to have about \$82 million lying around, he or she could even buy a painting by Renoir to hang on the walls of the house . . . [a] strategy [called] 'burying money in the treasure chest of the house.'"⁶¹

- **A home and all contiguous property** up to an equity value of \$750,000 as long as the AR expresses a subjective "intent to return" to the home. Federal law guarantees exempt home equity of at least \$500,000, but California opted for the maximum allowable exemption instead. The exemption includes a "mobile home, houseboat, or an entire multi-unit dwelling as long as any portion serves as the principal residence of the applicant."⁵³ "[W]hen the home is exempt, it can be transferred without penalty and without affecting the Medi-Cal eligibility."⁵⁴ The Omnibus Budget Reconciliation Act of 1993 made the transfer of an exempt home a penalizable transfer of assets except when the transfer is done to a spouse or other specified relative, but California has apparently not implemented that supposedly mandatory provision of the federal law.⁵⁵
- **One business** including the capital and cash flow of unlimited value is exempt.⁵⁶ Rental property may be exempt if it is "used in whole or in part as a business or as a means of self-support" and is "not just investment property."⁵⁷
- **Household goods and personal belongings**, including "heirlooms,"⁵⁸ are totally exempt.⁵⁹
- **One automobile of unlimited value** if used for the benefit, medical or otherwise, of the Medi-Cal recipient.⁶⁰ Because it is exempt, giving away an auto is not a transfer to qualify for Medi-Cal, so such a gift incurs no eligibility penalty. Thus, people can give away, buy, and give away cars until they reach the \$2,000 asset limit, based on this so-called "Two Mercedes Rule."
- **Unlimited prepaid burial plans** for the Medi-Cal recipient and everyone in his or her immediate family.⁶² Medicaid eligibility workers in other states estimate that between 65 percent and 80 percent of all Medicaid LTC recipients have prepaid for burial costs for themselves and/or family members.⁶³ Such burial costs usually vary from \$5,500 to \$7,500 in California; cremation alone averages around \$2,000.⁶⁴ Educators and the funeral profession routinely "explain to students and families that they can protect that money" from Medi-Cal spend-down requirements.⁶⁵

Funeral and burial pre-planning is a big business in California, including its use for Medi-Cal qualification.⁶⁶ Fraud is a problem according to an audit that found “\$70 Million in Prepaid Funeral Money Misused.”⁶⁷ Heavy use by Medi-Cal recipients of prepaid burial plans to shelter otherwise countable assets has the effect of shifting scarce program resources from purchasing long-term care services for the poor to subsidizing the funeral industry and indemnifying adult children from the cost of burying their parents.

- **Unlimited term life insurance.**⁶⁸ Why would a 90-year-old buy a million-dollar term life policy? Instantaneous self-improvement, eligibility for Medi-Cal LTC and other medical services covered by Medi-Cal but not by Medicare, and no estate recovery liability because the insurance benefits pass to heirs without going through probate.
- **Individual Retirement Account** assets and pensions in the applicant’s or recipient’s name⁶⁹ are uncounted as long as the AR is receiving periodic interest and principal payments.⁷⁰

These MMMNA and CSRA standards are the most generous spousal impoverishment protections permitted under federal law, far more bountiful than most states allow.

As generous as these basic eligibility rules for individuals are, married applicants qualify even more easily. Spousal impoverishment protections passed in the federal Medicare Catastrophic Coverage Act of 1988 (MCCA ‘88) ensured that spouses of Medicaid recipients would no longer be driven into poverty by rules that require healthy spouses to contribute toward the cost of caring for their husbands or wives.

MCCA ‘88 provided that the community spouse of an institutionalized Medicaid recipient would be allowed to retain at least half the couple’s joint assets not to exceed \$60,000 and up to \$1,500 per month of income, adjusted annually for inflation.

Today in California, community spouses may retain \$2,739 per month of income and \$109,500 in assets.⁷¹ California voluntarily chose to adopt the *federal maximum* monthly maintenance needs allowance (\$2,739) as its *minimum* monthly maintenance needs allowance (or MMMNA) and the *federal maximum* community spouse resource allowance (CSRA) as its *minimum* CSRA. These MMMNA and CSRA standards are the most generous spousal impoverishment protections permitted under federal law, far more bountiful than most states allow.

Medi-Cal Planning

California's Medi-Cal LTC eligibility rules are as elastic as they are munificent. A specialized practice of elder law called "Medi-Cal Planning" uses both simple and sophisticated legal techniques to qualify relatively well-to-do people for publicly funded long-term care.

The most common method to qualify people with too many assets for Medi-Cal LTC is the simple practice of purchasing exempt resources. Medi-Cal planners routinely advise their clients – who are usually the adult heirs, not the frail or infirm elders themselves – to buy things that do not count toward their \$2,000 asset limit.

Planners often provide a checklist of exempt assets to remind clients they may shelter funds in the home by paying off a mortgage or adding a room or by purchasing any of the exempt assets listed above.⁷²

For families with substantial non-exempt assets, usually hundreds of thousands of dollars, who can afford their services, Medi-Cal planners use complicated legal techniques to divest or shelter their wealth. Common methods include half-a-loaf or reverse half-a-loaf strategies, irrevocable income-only trusts, Medicaid-friendly annuities, and life care contracts. A rule of thumb is that the cost in attorney's fees to qualify for Medi-Cal after care is needed is approximately equal to one month of the private pay costs of staying in a nursing home.

Many other attorneys and non-attorneys dabble in the practice of artificially impoverishing clients to qualify them for Medi-Cal LTC benefits.

Medi-Cal planning advice is universally available throughout California, as an Internet search will show. The National Academy of Elder Law Attorneys, the Medicaid planners' professional association, lists 258 members in the state. Many other attorneys and non-attorneys dabble in the practice of artificially impoverishing clients to qualify them for Medi-Cal LTC benefits.

Medi-Cal planning is problematical for many reasons, not the least of which is that affluent people who self-impoverish to qualify often command access to the nicest facilities—to the exclusion of the poor. Planners advise them to hold back "key money" so they can pay privately for care at first. The best nursing facilities with the fewest "Medi-Cal beds" roll out a proverbial red carpet to attract patients who pay privately, because they pay at a rate often half again as much as Medi-Cal's. Unfortunately, poor people don't have key money and they tend to end up in the less desirable facilities more heavily dependent on lower Medi-Cal reimbursements.

The California Advocates for Nursing Home Reform (CANHR) explains this inequity in a section of its "Medi-Cal Overview" titled "Ethical Considerations": "Property reduction requirements can usually be easily handled and documented, and it can be tempting for many attorneys to advise clients to reduce excess property on the purchase of exempt assets prior to a nursing home entry. *It may be difficult however, to find a nursing home placement for a person who has spent all of his/her resources or who has few resources. . . . In most cases, they are unwilling to accept Medi-Cal eligible residents upon admission.*

The longer a person can pay privately, the more options there are available regarding nursing home placement. In addition, *a private pay patient may receive a higher level of service, e.g., a private room*, although relatives of nursing home residents are now permitted to supplement the Medi-Cal rate to pay for non-covered services such as a private room, television or phone services.⁷⁷ (emphasis added) Such “family supplementation” was originally prohibited by federal Medicaid law because of the inequity caused when recipients lucky enough to have rich relatives received more favorable treatment than others.

Internet Ads for Medi-Cal Planning

(1) MEDI-CAL ELIGIBILITY PLANNING TO QUALIFY FOR MEDI-CAL BENEFITS.

There are three very important areas to consider in developing a comprehensive Medi-Cal plan: 1. Eligibility Planning—to qualify for Medi-Cal benefits; 2. Income Planning—to reduce or eliminate a Medi-Cal beneficiary’s monthly “share of cost” co-payment; and 3. Medi-Cal Estate Recovery Planning—to reduce or completely eliminate Medi-Cal estate recovery against the beneficiary’s estate.

Our office will carefully review your assets, income and estate planning documents to develop a comprehensive Medi-Cal plan tailored to your specific situation. We typically offer our clients several alternative strategies and thoroughly review each strategy with our clients so that they can make an informed decision regarding how they would like to proceed.⁷³

(2) We help preserve your assets! We fill out all the forms and handle all communications with the Social Service Department! We have a 100% Approval Rate. We *guarantee* to qualify your loved one for Medi-Cal benefits!!⁷⁴ (original emphasis)

(3) Medi-Cal Planning is about asset preservation. It involves the purchasing, transferring, conversion and/or liquidating of assets to enable you or your loved one to qualify under Medi-Cal’s test of income and resources. . . . Due to changes in federal laws enacted in 1996, *almost anyone can qualify under Medi-Cal’s eligibility tests*. This is done by working within the complex rules and regulations of Medi-Cal, and the planning may be different from one individual to the next. It all depends on your personal set of circumstances and objectives. . . . The Medi-Cal rules are very complex, and change every year. Since an improper transfer may result in a period of ineligibility up to 5 years, you need to consult with a qualified Elder Law Attorney before attempting to qualify for Medi-Cal benefits.⁷⁵ (emphasis added)

(4) With an assortment of Medicaid Compliant Products and Services available, Krause Financial Services is able to meet almost any crisis Medicaid planning need, no matter how large or small. Whether the need is for a small life insurance policy or for a complicated Medicaid Compliant Annuity Plan, Krause Financial Services strives to provide total satisfaction in every case.⁷⁶

History of efforts to curtail Medicaid planning abuse

Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 authorized state Medicaid programs for the first time voluntarily to (1) “look back” two years to identify and penalize asset transfers done for the purpose of qualifying for Medicaid, (2) place liens on real property in order to hold that property in a recipient’s possession during their period of Medicaid eligibility, and (3) recover the cost of their care from the estates of deceased recipients.

Consolidated Omnibus Budget Reconciliation Act of 1985 put a stop to “Medicaid qualifying trusts.”

Medicare Catastrophic Coverage Act of 1988 made asset transfer penalties mandatory and extended both the look-back period and maximum eligibility penalty to 30 months from two years. The penalty was determined by a ratio of the below-market value of the transferred assets and the average monthly cost of a nursing home. For example, suppose a person transferred assets for \$50,000 below market value, within the 30-month look-back period. If the cost of a nursing home was \$5,000 per month, the person would be ineligible for Medicaid LTC for 10 months ($\$50,000/\$5,000$). However, even if a person transferred assets for a million dollars below their market value, his ineligibility would be capped at 30 months. Furthermore, the start-date of the penalty was the date of the assets’ transfer, rather than the date of application to Medicaid LTC, often rendering the penalty ineffective.

The Omnibus Budget Reconciliation Act of 1993 extended the look-back to three years (five years for trusts), removed the 30-month cap on eligibility penalties, and made estate recoveries mandatory.

The Health Insurance Portability and Accountability Act of 1996 made it a crime, punishable by a year in jail and a \$10,000 fine, to transfer assets for less than fair market value to qualify for Medicaid. Called the “Throw Granny in Jail Law,” it was unenforced.

The Balanced Budget Act of 1997 repealed “Throw Granny in Jail” and made it a crime, also punishable by a year in jail and \$10,000 fine, for attorneys to recommend transferring assets to qualify for Medicaid. Known as the “Throw Granny’s Lawyer in Jail Law,” it was unenforced, blocked by court action.

The Deficit Reduction Act of 2005 extended the look-back period to five years for all asset transfers, capped the Medicaid home equity exemption at \$750,000, and changed the penalty start date to curtail “half-a-loaf” planning, as described below.

OBRA '93 and DRA '05

Several Congresses and presidents have tried for decades to rein in the overuse of Medicaid LTC benefits by the affluent and to target scarce public resources to people most in need.

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) and the Deficit Reduction Act of 2005 (DRA '05) are two of the most noteworthy legislative measures aimed at closing eligibility loopholes and encouraging the recovery of sheltered assets from recipients' estates in order to reimburse Medicaid for their care.

OBRA '93 extended the look-back period (during which assets transferred for less than fair market value to qualify for Medicaid can cause an eligibility penalty) from 30 months to 36 months and eliminated the cap on the penalty, which was previously no more than 30 months. As a result, this should have made some people completely ineligible. Looking at the previous example: If a person had transferred assets for \$1 million less than their market value, and the monthly cost of a nursing home was \$5,000, the ineligibility penalty would be 200 months. OBRA '93 also made estate recovery, which was previously voluntary, mandatory for state Medicaid programs.

The DRA '05 put the first cap ever on Medicaid's home equity exemption, extended the look-back period on asset transfers from three to five years, and prohibited the single easiest and most common Medicaid planning technique, the half-a-loaf strategy. In this scheme, people give away half their wealth, shelter the rest, and qualify in half the time intended by the penalty for transfer of assets.

The problem in California is that Medi-Cal has not implemented key provisions of OBRA '93 nor most provisions of DRA '05. Despite the fact that stipulations in both federal laws are mandatory and long past due for implementation, Medi-Cal still uses the older, more lenient—and far more costly—rules. For example:

- Medi-Cal only looks back 30 months for “illegal” asset transfers while ignoring the mandatory look-back periods of 36 months in OBRA '93 and 60 months in DRA '05.⁷⁸

Why “half-a-loaf” matters

The Deficit Reduction Act of 2005 changed the start date for the asset transfer eligibility penalty from the date of the transfer until the date of Medicaid application. When the asset transfer penalty began at the date of the transfer, it usually expired before anyone applied for assistance. That enabled people, as noted above, to give away half their wealth, shelter the rest, and qualify in half the time intended by the transfer of assets penalty.

Now that the penalty begins when the person applies for Medicaid, there's no advantage to transferring half the assets. The penalty begins at the same time as the person would have been eligible under the old rules.

California, however, has not implemented this provision of DRA '05, so most people can still avoid maximum asset transfer penalties most of the time.

- The maximum eligibility penalty for asset transfers remains 30 months under Medi-Cal, despite the fact that federal law has permitted no limit since OBRA '93.⁷⁹
- Medi-Cal has not implemented the DRA '05 rule that requires the eligibility penalty to begin at the date of Medicaid application instead of the date of the asset transfer, which allows the commonest, easiest and most expensive Medicaid planning technique—the half-a-loaf strategy—to remain viable in California.⁸⁰
- Medi-Cal still allows recipients to transfer assets before income to bring the community spouse up to the minimum monthly maintenance needs allowance. This means that despite the DRA '05's prohibition of the practice, Medi-Cal still allows people to fill the gap between a spouse's personal income and the MMMNA with the interest (low) on assets (high) transferable from the Medi-Cal spouse. This practice can divert hundreds of thousands of extra dollars from Medi-Cal spend-down requirements.

The Income First Rule

A rule of Medi-Cal planning says: “Transfer assets before income.” Here's why:

“[I]f the community spouse's monthly income is less than the MMMNA of \$2,739, he/she may receive an allocation from the institutionalized spouse's income; file for a fair hearing to increase the CSRA to generate additional income; and/or obtain a court order to obtain additional income-generating resources. With current miniscule interest rates, it is relatively easy for a community spouse to retain assets above the CSRA, if his/her income is low.”⁸¹

Example: Let's say the Medi-Cal spouse has lots of income (income rarely causes ineligibility because of the share-of-cost rules) and lots of assets. Let's also say the community spouse's only income is \$1,000 per month in Social Security payments. Transferring income to get him/her up to the \$2,739 MMMNA would gain the couple nothing. But transferring assets so that the interest on the assets fills the \$1,739 per month income gap is a huge savings. How much money could the Medi-Cal spouse transfer to the community spouse over and above the \$109,500 otherwise allowed as the CSRA?

Let's figure it out. To maximize the transferable assets you want to find the lowest possible interest rate. So use the recent three-month Treasury bond yield of .11 percent per annum. We get to make up \$1,739 per month or \$20,868 per year to bring the spouse up to the MMMNA. To generate that much extra income at an interest rate of .11 percent, the community spouse would need to receive and invest \$18,971,000 from the Medi-Cal spouse. Such a high amount isn't likely, of course, but it does prove the meaninglessness of spousal income and asset limits in the absence of an income-first rule.

That's why the DRA '05 made “income first” mandatory⁸² and why California should comply with the law.

- Medi-Cal still does not count partial months of ineligibility as required by DRA '05, resulting in longer periods of eligibility than permitted under federal law. As a result of this loophole the state ignores otherwise penalty-triggering asset transfers up to the average monthly price of a private nursing home minus one dollar.⁸³
- DRA '05 treats the purchase of a life estate as an impermissible asset transfer under certain circumstances which Medi-Cal continues to allow.
- Although California has not implemented most of the DRA '05 provisions, the state did pass special legislation placing a first-ever limit on Medi-Cal's home equity exemption at the maximum allowed by the legislation, \$750,000. For comparison, the United Kingdom allows a home equity exemption of only 23,500 British pounds, approximately \$37,130 at a recent exchange rate of \$1.58.⁸⁴

All mandatory provisions of OBRA '93 should have been implemented many years ago. They have been implemented fully in most, if not all, other states. We could not ascertain which other provisions of OBRA '93 have yet to be implemented in California, whether Medi-Cal intends to implement any of the remaining requirements, or why the federal regional (San Francisco) and headquarters offices of the Centers for Medicare and Medicaid Services have not yet required compliance with the law.

Federal regional (San Francisco) and headquarters offices of the Centers for Medicare and Medicaid Services have not yet required compliance with the law.

DRA '05 stipulated that its provisions take effect as of "the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act." The DRA '05 was enacted February 8, 2006. Nevertheless, according to a June 1, 2010, update by CANHR: "The Department of Health Care Services has its hands full right now, so it is not likely that regulations implementing SB 483 (Kuehl)—the DRA implementation legislation—will be promulgated this year and no changes are expected for at least another year, since it takes a while to promulgate regulations."⁸⁵

Medi-Cal's Impact on LTC Providers

So far, this report has explained how long-term care has become a huge financial burden for California, why demographics will make the problem much worse in the future, how Medi-Cal has rebalanced itself from paying for services people would rather avoid (nursing homes) to services they prefer (home care), and why most Californians qualify easily for Medi-Cal-financed long-term care when the need arises. What effects have these developments had on long-term care providers?

We interviewed members and staff of major California trade associations for nursing homes, assisted living, home care, and adult day health.⁸⁶ Representatives of each industry group complained of excessive dependency on Medi-Cal, inadequate Medi-Cal reimbursement, too much unwarranted regulation, and the inability or unwillingness of the program to address its problems.

From the nursing home industry, we learned its biggest problems are a lack of confidence and consistency in Medi-Cal payments, workforce challenges exacerbated by low Medi-Cal reimbursements, over-regulation, and an inability to renovate and build new facilities.

We heard that Medi-Cal has ceased to be a welfare safety net for LTC and become an entitlement covering two-thirds of their residents. Furthermore, many private payers convert rapidly to Medi-Cal.

.....
 The state and private sector advisers find and execute ever-more-sophisticated methods to maximize federal funding.

The law compels Medicaid-qualified nursing homes to rebate such “retros” private payments and accept lower Medi-Cal payments retroactively.

Medi-Cal nursing home reimbursements are routinely delayed and, though better than before the state raised rates a few years ago, still only cover 90 percent of allowable costs—about 75 percent of private pay rates—and are starting to decline again.

One study observed that Medi-Cal reimbursement increases in the mid-2000s did not result in improved access and quality.⁸⁷ According to another study, however, Medi-Cal still pays nursing homes \$8.89 less than allowable costs on nearly 25 million annual bed days for a total loss of \$220 million per year.⁸⁸ Access and quality must be difficult to maintain, much less increase, while operating at a loss.

California levied “provider taxes”⁸⁹ on nursing homes meant to leverage up federal matching funds for Medi-Cal, but the state diverted a third of the proceeds to other programs instead of returning them to LTC, according to interviewees.

Using provider taxes to increase federal Medicaid matching funds and then refunding the taxes to the providers or using them to offset other state costs is tantamount to “wholesale Medicaid planning.” Instead of individuals and their attorneys gaming eligibility rules to qualify affluent clients for public

assistance, the state and private sector advisers find and execute ever-more-sophisticated methods to maximize federal funding. Health Management Associates' 2004 "Revenue Maximization Strategies Final Report"⁹⁰ is a good example of how states can shift their Medicaid budget liabilities to federal deficit spending. The author of that report, HMA's Vernon Smith, now says "there seems to be no end in sight to the fiscal pressure on the program. While there will be ongoing federal financial support for Medicaid to expand, many observers fear that relying on these continued infusions will be ultimately unsustainable given the nation's rising deficit."⁹¹

California's focus on "rebalancing" toward home care may be the right thing to do, but it does not save money, interviewees told us. Nor will cutting back on home care programs force people into nursing homes and drive up costs as home care advocates warn, because nursing homes are allowed to serve only the very highest acuity patients under current rules. If the bottom falls out of Medi-Cal home care funding, people won't have nursing homes to fall back on as before.

Assisted living providers have an entirely different point of view from nursing homes. They are almost entirely private pay and, with the exception of a tiny, 1,000-slot Medi-Cal waiver program, they receive no funding from the welfare program.

Still, assisted living has its own problems which make any new source of revenue tempting, including Medi-Cal. The economic downturn has hurt the industry in many ways, making it hard for people to sell their homes so they can afford to move into assisted living or forcing elders to take back financially struggling adult children into their traditional family homes.

With occupancy at 87 percent and only now beginning to rise from the recessionary trough, assisted living facilities (ALFs) would rather have some revenue than none from their empty beds. But accepting Medi-Cal is a slippery slope, interviewees explained.

One AL waiver provider complained Medi-Cal isn't paying its bills and currently owes his company \$8,000. Another went through the entire Medi-Cal AL waiver application process, during which he found the state was willing to waive "prohibitive conditions" such as the fact that his facility was unequipped to handle intravenous feedings, stage-3 decubitus ulcers, medication administration, and bed-bound patients. However, Medi-Cal would not allow two or three residents in an apartment, even with private bedrooms. Ironically, shared apartments are in demand by private payers who seek to save money but Medi-Cal will not allow apartment sharing by its recipients.

The real killers for ALF participation in Medi-Cal are (1) the state's unwillingness to pay more than two-thirds to three-fourths of private pay rates, rendering the public program financially infeasible, and (2) Medi-Cal's insistence that ALFs accept high-acuity patients, who really belong in nursing homes. Interviewees pointed out the new Medi-Cal AL waiver rule that half of all participants must come directly from nursing homes and not from the community. It is unlikely Medi-Cal will entice many high-quality assisted living facilities to participate at reimbursement rates the program is willing to pay.

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Home health care providers said their biggest concerns were over-regulation and the absence of Medi-Cal funding during the budget hiatus periods that occur whenever the Legislature fails to pass a budget on time. One provider said 60 percent to 70 percent of his business is with the state, but he received no payment from the end of August until the date of our interview, September 14, 2010. Another said Medi-Cal owes him \$100,000.

IHSS also crowds out affordable, market-based, private-pay home care services.

Despite the lack of Medi-Cal reimbursement, home health providers are still expected to carry on providing services. Adding insult to injury, the state continues to pay nursing homes during these budget gaps, the very venue of care Medi-Cal says it wants to discourage in favor of less expensive home and community-based care. The home health industry has not had a Medi-Cal rate increase since the year 2000, has suffered several decreases of 5 to 10 percent, and would be receiving 1993 rates now if Medi-Cal were paying at all.

Medi-Cal rates are considerably below private-pay rates, especially for the massive In-Home Supportive Services program. IHSS pays Medi-Cal workers only a little more than minimum wage; according to our interviewees, the program is “fraught with abuse” because it pays for care provided by family members, who often don’t. IHSS also crowds out affordable, market-based, private-pay home care services.

“We end up torn between helping patients or business survival,” concluded one interviewee. His proposed solution: stop paying family members to provide care, have home health agencies administer the In-Home Supportive Services program, and make sure publicly funded home care is a safety net, not an entitlement.

Adult day health care (ADHC) is an extraordinary service, according to the executive director of the California Association for Adult Day Services (CAADS). For \$78 to \$80 per day, ADHC providers offer a range of social, transportation, and health care services that enable people to remain in their homes who would otherwise go to nursing homes. Arguably, ADHC saves Medi-Cal and Medicare money by restoring people to healthy independence and keeping them stable.

Medi-Cal covers 90 percent of ADHC users. Private pay covers most of the rest, and LTC insurance provides a trickle of funding. So the success of ADHC depends heavily on support from Medi-Cal. How well has Medi-Cal supported ADHC? During the absence of a state budget, the state doesn’t pay ADHC providers. Some services—such as Alzheimer day grants, dental, vision, hearing and speech therapy—that enable ADHC to support the medical, cognitive, and custodial needs of the “whole” person have been eliminated entirely or, in the case of mental health services, curtailed substantially.

On top of everything, Gov. Schwarzenegger proposed to cut adult day health services from Medi-Cal completely. Opposition in the Legislature and a lawsuit by disability rights advocates prevented total elimination of the program. But a moratorium on new ADHC operations, a three-day cap on services, and the fact that Medi-Cal has not paid reliably for its services have left the ADHC industry in dire condition. Emails are pouring into the trade association from ADHC providers who are brokenhearted because they cannot carry on much longer. Once they’re gone, such programs are unlikely to return due to high start-up costs and funding shortfalls.

LTC Financing Sources That Could Relieve the Pressure on Medi-Cal

Any objective assessment of California's long-term care service delivery and financing system must acknowledge its heavy reliance on Medi-Cal, the severe fiscal problems the state and that program face, the likelihood that financial challenges will worsen as the Age Wave crests and crashes, and the relative lack of private long-term care financing sources that could relieve the pressure on Medi-Cal.

There are really only four sources of private financing that might offset Medi-Cal long-term care expenditures. These are (1) increased personal asset spend-down, (2) Medicaid estate recovery, (3) home equity conversion, and (4) private long-term care insurance. How well does California take advantage of these potential resources?

As explained above in our discussion of Medi-Cal long-term care eligibility rules and Medi-Cal planning, *asset spend-down* for long-term care is very easy to avoid in California. Some people do pay privately for LTC in the state for three common reasons. The poor, who are unaccustomed to consulting financial advisers, often lose everything to high-cost LTC before they find their way to Medi-Cal. The middle class and affluent may voluntarily pay out of pocket for highly desirable care venues, such as assisted living, which Medi-Cal does not usually fund. People with private long-term care insurance or who can otherwise afford the sentiment may pay privately because of a sense that turning to public welfare is unethical.

In the end, however, Medi-Cal is the dominant LTC payer and out-of-pocket expenditures are relatively small because of (1) easy access to Medi-Cal financing after care is needed, (2) the widely held belief that access to publicly financed long-term care is a "right," both legally and ethically appropriate for anyone who follows the lenient income and asset rules and (3) readily available legal advice on how to qualify for Medi-Cal without spending down assets.

Medicaid estate recovery is another source of private financing for long-term care that is mandatory under federal law and expressly intended to relieve the financial burden on state and federal resources. California has an active Medi-Cal estate recovery program. But according to the latest available published data, Medi-Cal recovered only \$45 million in 2004 or 1.5 percent of nursing home expenditures, ranking California 12th among recovery states.⁹² Oregon, the top-ranked state among comparable estate recovery programs, recovered \$14 million or 5.8 percent of its Medicaid nursing home expenditures. If California had recovered at the same rate as Oregon in 2004, Medi-Cal would have brought in \$131 million more. Although we heard anecdotally that annual Medi-Cal estate recoveries exceeded \$100 million in a recent year, we were unable to obtain actual recovery amounts for the years since 2004 from the Department of Health Care Services or the Legislative Analyst's Office.

How to Avoid an Estate Claim

According to California Advocates for Nursing Home Reform, estate recovery is easy to avoid:

How to Avoid an Estate Claim

The best way to avoid an estate claim is to have nothing in the Medi-Cal beneficiary's estate at the time of death. The State can only claim for the amount of Medi-Cal benefits paid or the value of the estate, whichever is less. The "estate" is composed of what is in the beneficiary's name at the time of death. Minimizing the estate at the time of death will minimize the amount of the claim.

The main asset in the estate is often the home. Protecting the home from recovery often entails transfer of title out of the beneficiary's name. However, there are a number of ways to transfer property and still retain some control over the property. Any such transfer should be discussed with a qualified estate planning attorney knowledgeable about Medi-Cal and the tax considerations related to real estate transfers.⁹³

We requested the opportunity to interview Medi-Cal estate recovery staff about program policies, procedures, and statutory authorities in order to compare California's program with Oregon's. Medi-Cal denied our request.

One key point of interest is whether or not California recovers from the estates of deceased spouses of pre-deceased Medicaid recipients. GAO estimated in a 1989 report that California "could recover an additional \$11 million [per year] if the state enacts legislation to authorize recoveries from the estates of the surviving spouse when he or she, in turn, dies."⁹⁴ Did the state follow that advice? Has Medi-Cal's estate recovery program sought statutory authority to implement other best practices identified in the GAO report and in a similar 1988 report by the Inspector General of the U.S. Department of Health and Human Services?⁹⁵ It behooves policy makers concerned about Medi-Cal's financial viability to find out and correct any deficiencies.

Home equity conversion by means of reverse mortgages could generate a huge source of private long-term care financing to offset Medi-Cal LTC expenditures, especially to fund home- and community-based services. Most Californians, 56.9 percent, own their own homes, fewer than the national average of 66.2 percent.⁹⁶ Nationally, more than 80 percent of seniors own their homes and more than 70 percent of these own their homes free and clear of mortgage debt.⁹⁷

People age 62 and older can access their home equity easily, and without incurring monthly payments, by means of "reverse mortgages."⁹⁸ But very few people use reverse mortgages to fund home- and community-based services that would enable them to remain in their homes longer. Even fewer tap their home equity to supplement their income sufficiently to afford private LTC insurance premiums.

California reverse mortgage lenders we interviewed for this study indicated that 80 percent of all reverse mortgages taken out in the state are used to pay off an underlying mortgage in order to free up income. The interviewees had seen some examples of reverse mortgage loans to fund home improvements for the aging, such as grab bars for bathrooms, but such use of the loan is uncommon.

Why is home equity so rarely used to fund long-term care in California? The median value of California homes as of September 1, 2010, was \$343,700.⁹⁹ Medi-Cal's home equity exemption is \$750,000, nearly double the value of the median home. There is little wonder why few people tap the equity in their home to fund long-term care or to purchase LTC insurance when Medi-Cal financing is easy to obtain and, according to the Web sites of CANHR and many Medi-Cal planners, estate recovery is simple to avoid in California.

On top of these reasons, reverse mortgage interviewees told us the product is heavily regulated in many regards, requires extensive outside counseling prior to closing, and receives a great deal of negative publicity, much of which is inaccurate and unfair. So, our interviewees explained, education of consumers, suitability of marketing, and fair evaluation of products are keys to the widest and most appropriate use of reverse mortgages for any purpose, including long-term care financing.¹⁰⁰

Private long-term care insurance is another potentially large funding source that could relieve Medi-Cal. Responsible people mitigate potentially catastrophic financial risks with private insurance. Most Californians have auto and health insurance; many own life insurance; but relatively few have long-term care insurance. Roughly 567,000 LTC insurance policies were in force in California as of 2008, up 3.1 percent from 2007.¹⁰¹ That may sound impressive until you realize California has 10,430,272 citizens over the age of 50, the prime market for long-term care insurance.¹⁰² The product's market penetration is therefore only 5.4 percent.

Why isn't private long-term care insurance more commonly purchased? An April 2010 poll of voters 40 years and older showed they do worry about paying for long-term care (66 percent) because they could not pay for more than three months of nursing home care (68 percent). Still, most do not own insurance coverage for the risk. Only 15 percent said they have it and likely many of those were mistaken: 69 percent incorrectly thought Medicare pays for long-term nursing home care and 78 percent had the same incorrect view regarding in-home care.¹⁰³

The usual reasons cited for the low rate of purchase are consumers' irrational denial of the risk and the product's unaffordability. But the risk and cost of long-term care are extremely high and well documented. The cost of LTC insurance is high but the cost of the risk being insured is much higher still. If every tenth house burned down, fire insurance would not be cheap either. So, the key question is: how can consumers remain in denial about such a huge risk and cost? What is the real reason most people do not purchase private long-term care insurance?

Published, peer-reviewed research confirms that between two-thirds and 90 percent of the private long-term care insurance market is crowded out by the availability of Medicaid-financed long-term care.¹⁰⁴ People don't fail to purchase private long-term care exclusively, or even mostly, because of denial or cost. Rather, they don't buy it because they don't think they need it and they don't think they need it because Medi-Cal has paid for most expensive long-term care in California since the program's inception in the

Little wonder why few people tap the equity in their home to fund long-term care or to purchase LTC insurance when Medi-Cal financing is easy to obtain.

late 1960s. In fact, the easy availability of Medi-Cal services after the insurable event occurs has enabled the public's denial of LTC risk and cost.

The easy availability of Medi-Cal services after the insurable event occurs has enabled the public's denial of LTC risk and cost.

Compounding the problem is that CalPERS, which provides benefits to most of California's public-sector workers, offered a poorly designed LTC plan as a voluntary benefit to its beneficiaries. "Last year saw a huge budget deficit of more than \$800 million, the biggest since 2007. Eight of the last 10 years have been in the red. The plan's investment portfolio lost 16.2 percent of its value last year; over the previous five years, it's grown an anemic 1.9 percent. It's been more than two years since people could join. Though there have been three big rate hikes since 2003—the most recent, in 2009, was 22 percent—operating revenues have either stagnated or dropped."¹⁰⁵

Interviewees told us CalPERS topped out at 300,000 insured lives,¹⁰⁶ but is down to 160,000 now.¹⁰⁷ The second largest LTC insurance plan in the country,¹⁰⁸ CalPERS used lax underwriting— "we used to send people who couldn't qualify medically to CalPERS," said agents interviewed – and has consequently had three rate increases in the past seven years totaling 74 percent.¹⁰⁹ Its board has not met in two years; staff cannot be reached for answers required by mandatory training updates.¹¹⁰ Still, most media criticism of long-term care insurance has been levied at a few private firms that also had poor results.

The California Long-Term Care Partnership program, under which less affluent people can purchase LTC insurance and be forgiven Medi-Cal spend-down liability in the same amount that the insurance pays, got off to an excellent start. California was one of the first pilot states to implement the Partnership program in the early 1990s. But lately, it too has languished.

The program has "no budget and a caretaker staff;" the state never used its full credibility to give the Partnership program a 'Good Housekeeping Seal of Approval'.¹¹¹ Consumer advocate Bonnie Burns said, "We put a lot of time and effort into the development of that program," but "I think the state is just letting it die."¹¹² LTC insurance industry interviewees said the Partnership program is "dead in the water and is going to get deader. New companies can't get policies approved. Self-styled consumer advocates lobbied for a mandatory 5 percent increase in premiums, compounding annually, rendering the product unaffordable. The old structure of Partnership plans cannot be saved, but officials are afraid to change the rules. They've missed the market. Change or die."¹¹³

Bottom line: "California's citizens are being deprived the right to purchase many of the newest and most popular long-term care insurance policies that are being sold nationwide. The industry insiders know this, but have not been able to do much about the situation in California."¹¹⁴

Finally, California offers citizens no tax incentive to purchase long-term care insurance beyond the pass-through of a meager federal deduction. Few prospective purchasers of LTC insurance qualify for the federal deduction or the state pass-through. That is because the deduction is granted only after

one's medical expenses, including a limited portion of one's LTC insurance premiums, exceed 7.5 percent of adjusted gross income. Even that limit will increase to 10 percent because of the Affordable Care Act, i.e., health reform.¹¹⁵ Most people who are sick enough to qualify for a tax deduction based on medical expenses are therefore too sick to qualify for LTC insurance, a catch-22. Some states offer much stronger incentives including tax deductions, tax credits, or both in addition to, or instead of, the federal deduction pass-through.¹¹⁶

California offers citizens no tax incentive to purchase long-term care insurance beyond the pass-through of a meager federal deduction.

The CLASS Act

California desperately needs a better way to finance long-term care. Since Medi-Cal began, the state has had a very expensive, welfare-financed, nursing home-based LTC system that is plagued by problems of access, quality, reimbursement, discrimination, institutional bias, loss of independence, and welfare stigma.

The Community Living Assistance Services and Supports Act (CLASS) program, which passed as Title VIII of the Affordable Care Act,¹¹⁷ attempts to address some of these deficiencies by creating a new national source of private financing for LTC controlled by people who need care and enabling them to purchase the care they prefer in their home or community instead of an institution.

Those are noble goals, but CLASS may not achieve them. Worse yet, CLASS may obstruct achieving the same goals by the only means that can succeed. Here's why.

CLASS has no medical underwriting so it does not price risk. It will likely experience severe adverse selection and slip quickly into what insurers call a death spiral.¹¹⁸

CLASS premiums, "triggers," and benefits are unknowable at the outset¹¹⁹ because they will depend on what the Secretary of Health and Human Services decides the program can afford.¹²⁰

CLASS offers false hope for people in desperate need.

CLASS cannot survive without a high take-up to spread the risk and cost, but the program is so skewed against healthy, insurable people in favor of the realistically uninsurable that actuarial experts predict as few as 2 percent will participate.¹²¹

CLASS premiums are immediately spent by the federal government on other priorities and replaced by Treasury bonds, thus adding to unfunded entitlement liabilities that already exceed many trillions of dollars for Social Security, Medicare, and Medicaid.¹²²

CLASS is supposed to be fully funded privately; but when the bonds in its "trust fund" come due, taxpayers will have to repay the missing principal plus interest.¹²³

CLASS is "a Ponzi scheme of the first order, the kind of thing that Bernie Madoff would have been proud of," according to Kent Conrad (D-ND), chairman of the U.S. Senate Budget Committee.¹²⁴

Unfortunately, CLASS offers false hope for people in desperate need and further desensitizes others who should, could, and might plan responsibly for long-term care in a more rational system.

We asked our interviewees about the CLASS Act program. Most knew little or nothing about it.

One or two expressed high hopes the program would succeed. Pat McGinnis, executive director of California Advocates for Nursing Home Reform, was particularly effusive in her praise: “CLASS is going to be one of the most important aspects of LTC financing for this country. It is viable if they can fund it—a wonderful solution that will save Medicaid money.”¹²⁵

The single most knowledgeable person we asked, Jim Gomez, CEO and president of the California Association of Health Care Facilities, was very doubtful about CLASS. He ran the CalPERS long-term care insurance program during its growth from 50,000 to 300,000 policy holders and he understands insurance principles such as underwriting, adverse selection, and moral hazard. Gomez said “CLASS will learn hard lessons very shortly. I don’t believe it is a solution. People will not sign up for CLASS. It will become an unfunded mandate of the government. CLASS is asking to go bankrupt.”¹²⁶

The SCAN Foundation offered highly optimistic advice, diametrically opposite from ours, to California’s Little Hoover Commission in testimony on August 26, 2010: “*Support the CLASS program. . . . Help the State explore the potential to apply for enhanced Medicaid HCBS options.*”¹²⁷ (Emphasis added)

Conclusion

If Rene Descartes’ “evil daemon” intentionally designed a dysfunctional and ruinously expensive long-term care system, he could not do a better job than California has done, aided and abetted by the U.S. government. To conclude this report, we imagine how an evil genius might approach such a task and compare the result with California’s long-term care status quo:

- ☑ Trap aging Californians on welfare who’ve been self-sufficient all their lives.
- ☑ Discourage home care or assisted living by making nursing homes virtually free.
- ☑ Pay families to provide care they’d otherwise render at no charge.
- ☑ Drag care quality down with low government LTC reimbursements at all care levels.
- ☑ Make it hard for the poor to get public assistance for long-term care because of complicated, ostensibly strict income and asset limits.
- ☑ Make it easy for prosperous people to obtain publicly financed LTC with the help of legal “impoverishment” experts.
- ☑ Incentivize adult children to take early inheritances and place their parents on welfare.
- ☑ Allow lawyers to receive rich fees for using sophisticated legal techniques and financial products to qualify affluent clients for publicly financed LTC.
- ☑ Anesthetize the public to LTC risk and cost by paying for most long-term care through government programs.
- ☑ Choke off a market for private LTC insurance by paying publicly for most LTC after the insurable event occurs.
- ☑ Eliminate a potentially huge source of private LTC funding with a giant home equity exemption for public funding.
- ☑ Turn government-funded LTC into “free inheritance” insurance by failing to collect fully from recipients’ estates.
- ☑ Cap it all off with an actuarially unsound government long-term care “insurance” program (CLASS).

This report has shown how well-intentioned, but perversely counterproductive, public policy is ruining long-term care in California and contributing massively to the state’s financial problems.

Whatever the good intentions of legislators, public officials, and senior advocates, they have created a dominantly welfare-financed, nursing home-based long-term care system in the wealthiest country in the world where no one wants to go to a nursing home but most people remain in denial about LTC risk and fail to plan responsibly for the cost.

Clearly, California’s LTC safety net provides quality care for too few and a publicly funded long-term care “hammock” for too many.

General Recommendations

California's Medi-Cal long-term care service delivery and financing system is so deeply flawed and financially doomed that no set of specific recommendations within federal Medicaid rules could fix it. The state faces a Hobson's Choice on long-term care with fundamental change the only alternative to collapse. The basic problem is that Medi-Cal LTC does too much for too many too poorly. To survive, it needs to do more for fewer but better.

Unfortunately, even if Medi-Cal LTC stopped being more generous with eligibility and benefits than federal law allows, it could still not be strict enough to prevent overuse of the program. Federal Medicaid rules do not allow Medi-Cal to target scarce public resources to the neediest. Rather, they discourage responsible LTC planning and enable easy access to publicly funded care.

Worse, in the past couple years (since the economic stimulus program began)¹²⁸ and going forward (after health reform),¹²⁹ the federal government has infused Medi-Cal with massive extra funds (supplemental FMAP, or federal medical assistance percentage)¹³⁰ conditional upon California doing nothing to constrain eligibility. This so-called maintenance of effort requirement makes receipt of all federal Medicaid matching funds dependent upon the state doing nothing to restrict Medi-Cal LTC eligibility beyond the rules in effect as of July 1, 2008 (stimulus), or March 23, 2010 (health reform).¹³¹

According to California's Legislative Analyst's Office (LAO): "Under the enhanced FMAP, instead of sharing most Medi-Cal costs 50-50, the state-federal split is 38-62."¹³²

Massive amounts of money are involved, according to LAO: "For 2009-10, the budget includes \$34.5 billion in federal funds for H&SS [Health and Social Services] programs. Acceptance of these funds means that California must comply with federal program requirements."¹³³

As long as California attempts to operate its LTC safety net under federal Medicaid rules, it has no choice but to serve as a "hammock" that desensitizes the public to LTC risk and crowds out private financing alternatives like those discussed in this report.

One way to escape this fiscal pincer is to drop out of Medicaid. Dennis Smith, who ran Medicaid for eight years within the Centers for Medicare and Medicaid Services under the Bush administration, estimates that by terminating Medicaid participation starting in FY 2013 California could save \$126 billion in FY 2013-2019 with no change in state LTC spending. It could save \$133 billion with a 10 percent reduction in LTC spending.¹³⁴

As radical as dropping out of Medicaid may sound, it could happen anyway by default if the bottom falls out of state and/or federal financial support of the program, as seems increasingly likely. Furthermore, getting out from under federal Medicaid rules would allow California to implement a viable LTC safety net, eliminate perverse incentives that permeate the current system, and encourage responsible LTC planning to divert most Californians to private LTC financing alternatives.

Whether by leaving Medicaid or by seeking unique waiver authority or by doing all it can within existing federal rules, California should try to do the following:

- Clearly establish the principle that long-term care is a personal responsibility, not a social right.
- Conduct a comprehensive review of the current LTC service delivery and financing system to identify and eliminate policies that encourage public dependency.
- Incentivize the middle class and affluent to plan early and save, invest, or insure for LTC.
- Reduce the number of expensive Medi-Cal/Medicare “dual eligibles” in the future by diverting more Californians to private LTC financing alternatives while they are still young enough, healthy enough, and affluent enough to save, invest or insure for LTC.
- Stop expecting “rebalancing” to save money and start providing more home- and community-based services, but to fewer, needier recipients.
- Get out of the way of private markets. Encourage private-sector sources of financing such as greater asset spend-down, estate recovery, home equity conversion, and private long-term care insurance.
- Pay LTC providers adequately to ensure access to quality care at the most appropriate level for a much smaller caseload.
- Forget the chimera of the CLASS Act and insist on actuarially solvent private LTC insurance solidly grounded in well-established insurance principles.

Well-intentioned, but perversely counterproductive, public policy is ruining long-term care in California and contributing massively to the state’s financial problems.

Specific Recommendations

Because we were denied permission to interview Medi-Cal staff, we cannot say definitively what the program is doing in narrowly specific areas and therefore cannot recommend corrective actions conclusively in detail. Following are general observations based on what we do know about Medi-Cal LTC and what we've learned by conducting many similar studies in other states.¹³⁵ We include conservative estimates of potential savings.

- I. Find out how much potential private long-term care financing is diverted to rising Medi-Cal expenditures by conducting a “recovery audit”¹³⁶ of a valid random sample of Medi-Cal LTC cases with a focus on the following “leaks.”¹³⁷
 1. Medi-Cal’s adoption of maximum federal limits for its minimum Community Spouse Resource Allowance and Minimum Monthly Maintenance Needs Allowance.
 2. Assets transferred before Medi-Cal’s 30-month look-back and before the five-year transfer of assets look-back period established by DRA ’05, which Medi-Cal has not yet implemented.
 3. Losses due to Medi-Cal’s failure to lift the 30-month cap on the transfer of assets eligibility penalty as mandated by OBRA ’93.
 4. The \$750,000 home equity exemption.
 5. The unlimited business exemption.
 6. The unlimited automobile exemption.
 7. The unlimited prepaid burials exemption.
 8. The unlimited term life insurance exemption.
 9. The unlimited household furnishings exemption.
 10. Purchase of exempt assets to spend down to Medi-Cal resource limits.
 11. The “half-a-loaf” planning technique prohibited by DRA ’05 but still allowed by Medi-Cal.
 12. Medi-Cal’s failure to implement the “transfer income before assets” rule from DRA ’05.
 13. Medi-Cal’s not allowing “partial months of ineligibility” as required by DRA ’05.
 14. Irrevocable income-only trusts.
 15. Medi-Cal-friendly annuities.
 16. Purchase of life estates with special powers.
 17. Purchase of an interest in another’s home.
 18. Fraud or unintentional misrepresentation of personal finances.
 19. Other Medi-Cal planning techniques.
 20. Failure to pursue TEFRA liens.
 21. An un-maximized Medicaid estate recovery program.

Based on the findings of this review and analysis, California should develop a corrective action plan to close eligibility loopholes and discourage abusive Medi-Cal planning practices.

Even if California cannot be *more* restrictive than federal Medicaid law allows, by doing no more than becoming *as* restrictive as federal law allows, i.e., closing as many of the “leaks” described above as

possible, the state could certainly save between 1 percent (\$125,000,000) and 5 percent (\$625,000,000) of annual long-term care expenditures. The midpoint of these savings estimates is \$375,000,000.

- II. Either drop out of Medicaid or seek authority through a waiver from the Centers for Medicare and Medicaid Services to reduce Medi-Cal LTC eligibility exposure and to maximize private LTC financing alternatives.
 1. Extend the look-back period during which assets transferred for less than fair market value to qualify for Medicaid incur an eligibility penalty from five years (currently) to 10 years (as in Germany, a socialized health care system).¹³⁸
 2. Eliminate or radically reduce the home equity exemption for Medi-Cal LTC eligibility from \$750,000 (currently) to no more than \$37,130 (as in the United Kingdom, another socialized health care system).
 3. Preclude the use of trusts, annuities, promissory notes, the “half-a-loaf” or “reverse half-a-loaf” strategies and other Medi-Cal planning techniques to divest or shelter assets from Medi-Cal LTC financial eligibility limits.

Dropping out of Medicaid alone could save \$19 billion per year, including LTC savings based on an estimate of \$133 billion savings over seven years.¹³⁹

Short of dropping out of Medicaid, limiting LTC assistance to only the needy could make a big difference. If all Californians knew that funding long-term care would be a personal responsibility that could consume their savings and home equity, it is reasonable to assume that one quarter or more would prepare for that risk through savings, investment, or insurance. If even 10 percent of those who end up on Medi-Cal now were instead to pay for their own care through savings, home equity, or private LTC insurance, the program could save \$1.25 billion per year.

- III. Enhance California’s estate recovery program. (We were not given the opportunity to interview Medi-Cal estate recovery staff. Recommendations here are based on our reviews of Medicaid estate recovery programs in other states.)
 1. Conduct a study of successful estate recovery programs, especially Oregon’s, and implement best practices. Seek state legislative authority for changes that require it.
 2. Establish a TEFRA lien program to secure recovery of value from houses not needed by an exempt dependent relative.¹⁴⁰
 3. Hire more estate recovery personnel until the marginal rate of return is reached, i.e., add staff as long as each new hiring increases lien and estate recoveries.
 4. Require nursing homes to report deaths of Medicaid dependent residents to the estate recovery unit in order to supplement and expedite current methods of death notification and probate initiation.
 5. Establish the moral high ground of estate recovery by educating the public, the bar, and the judiciary about the importance of ending the use of Medicaid as “free inheritance insurance” for heirs.

6. Seek stronger authority to capture accounts held by nursing homes in the Medicaid recipients' names until estate liability is determined.
7. Establish a system to recover hard assets, including investment-grade property, from recipients' estates before the property is taken by heirs.
8. Expand repayment plans whereby families can satisfy their estate recovery liability over time. Allow them to retain ownership of homes or other property if they wish by repayment with interest through open-ended mortgages or contracts on deeds.
9. To eliminate all cost to the state and maximize recoveries, consider hiring an outside contractor on contingency to do estate recoveries in exchange for a percentage of the amount recovered.

Lacking access to state staff and data regarding Medi-Cal estate recoveries, we cannot predict with certainty how much more non-tax revenue the state could generate by maximizing this source. We can say, however, that based on the most recent published data, California could collect \$131 million dollars more per year by recovering at the same rate as Oregon, the national leader in estate recoveries.¹⁴¹

IV. Educate Californians about the importance of planning for long-term care.

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

V. Implement measures to encourage the use of reverse mortgages and private long-term care insurance to fund long-term care privately.

1. Consider both tax and Medi-Cal eligibility incentives to promote the use of reverse mortgages to fund long-term care privately.
2. Consult the National Council on the Aging's (NCOA) report titled "Use Your Home to Stay at Home" for additional ways to encourage the use of home equity conversion to fund LTC.¹⁴²
3. Publicize and expand California's Long-Term Care Partnership program.
4. Consider and implement tax incentives to encourage the purchase of private long-term care insurance.

Recommendations IV and V are the means by which California could achieve the \$1.25 billion savings per year estimated in Recommendation II. Education campaigns and tax incentives to encourage responsible LTC planning and private LTC financing alternatives cost money. But those costs can be covered by the savings that accrue immediately from limiting Medi-Cal LTC eligibility and maximizing estate recoveries.

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- 84 “[T]hose with assets – which in most cases will include the value of their home – of more than £23,500 are given no help at all with care costs.” “Long-term care: get the best deal now: A new commission is to investigate the best way of funding care for our ageing population. But what steps can families take now?” Telegraph.co.uk, July 21, 2010; <http://www.telegraph.co.uk/finance/personalfinance/7902277/Long-term-care-get-the-best-deal-now.html>.)
- 85 CANHR, “DRA Update: No Changes in 2010,” June 1, 2010, http://www.canhr.org/medcal/medcal_DRAImplementation031607.htm, retrieved September 27, 2010.
- 86 All such interviews occurred during the field work for this project in Sacramento from September 13-17, 2010.
- 87 “Although both Medi-Cal and total revenues in all types of facilities increased by \$590 million and \$1.1 billion respectively (between 2004 and 2006), nursing facilities in California did not show significant improvements in access to nursing home services as measured by increases in Medi-Cal days of care.” (Charlene Harrington, et al., “Impact of California’s Medi-Cal Long Term Care Reimbursement Act On Access, Quality and Costs,” Department of Social & Behavioral Sciences, University of California-San Francisco, April 1, 2008, p. vii; <http://www>.

- pascenter.org/documents/CHCF_NH_Reimbursement.pdf.)
- 88 According to research sponsored by the American Health Care Association, Medi-Cal reimburses California's nursing homes \$8.89 per bed day less than allowable costs for an estimated total of 24,703,382 annual "Medicaid days" and a total loss of \$219,613,064 in 2009. (ELJAY, LLC, "A Report on Shortfalls in Medicaid Funding for Nursing Home Care," for the American Health Care Association, November 2009, pps. 7, 30; http://www.ahcancal.org/research_data/funding/Documents/2009%20Medicaid%20Shortfall%20Report.pdf.)
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- 90 "In this report HMA identifies the revenue enhancement opportunities that appear to have the greatest potential for early success. All of these options are being utilized in other states and/or are being utilized in California but not to their full potential. None of the options suggested are unprecedented, but they are not necessarily easy to implement. They require leadership and investment along with inter-agency cooperation. Ideally the Governor's Office, legislative leadership, Health and Welfare Agency and Department of Health Services will concur regarding which options to pursue and what is required for success." Health Management Associates, "Revenue Maximization Strategies Final Report," a report prepared for The California Endowment, Los Angeles, California, December 2004, p. 1; http://www.healthmanagement.com/news_details.asp?newsarticleid=73.)
- 91 Dan Diamond, "Does Medicaid Need a Checkup?" California Healthline, October 6, 2010; <http://www.californiahealthline.org/road-to-reform/2010/does-medicaid-need-a-checkup.aspx>.
- 92 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief no. 6, September 2005, <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.
- 93 CANHR, "Your Home and Medi-Cal," last modified December 30, 2008, retrieved October 6, 2010; http://www.canhr.org/factsheets/medi-cal_fs/html/fs_medcal_your_home.htm.
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- “Based on the Health and Retirement Study, in 2000 there were 27.5 million elder households with at least one resident age 62 or older. A high proportion (21.1 million) of these households (78 percent) were homeowners (Figure 3.2). About 74 percent owned their homes free and clear of any mortgages. In aggregate, elder households have accumulated over \$2 trillion in home equity. [p. 26] Barbara R. Stucki, “Use Your Home to Stay at Home: Expanding the Use of Reverse Mortgages for Long-Term Care: A Blueprint for Action,” The National Council on the Aging, January 2005, <http://www.reversemortgagetimes.org/guides/reverselongterm.pdf>.)
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- 99 California Home Prices and Home Values, Zillow Home Value Index, September 1, 2010, http://www.zillow.com/local-info/CA-home-value/r_9/.
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- 107 Telephone interview on August 24, 2010, with Bonnie Burns, Training and Policy Specialist for California Health Advocates; <http://www.cahealthadvocates.org/>.
- 108 Telephone interview August 23, 2010, with Jesse Slome, Executive Director of the American Association for Long-Term Care Insurance; www.aaltci.org.
- 109 Interview on September 16, 2010, with LTC insurance representatives Arsenault, Bayham, Brownstone, Crews, Dorfi, and Nicholas. See list of interviewees for details.
- 110 Telephone interview on August 9, 2010, with Tom Orr, CEO, Senior Insurance Training, Sonoma, California; <http://www.ltce.com/page.cfm?PageID=127&CategoryID=34>.

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- 116 David Baer and Ellen O'Brien, "Federal and State Income Tax Incentives for Private Long-Term Care Insurance," AARP Public Policy Institute, Washington, DC, November 2009, <http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf>.
- 117 Patient Protection and Affordable Care Act (Enrolled as Agreed to or Passed by Both House and Senate) [PDF], AKA "Health Reform," aka "ObamaCare," signed by President Obama on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (Enrolled as Agreed to or Passed by Both House and Senate) [PDF], aka the "Fixer Bill," signed by President Obama on March 30, 2010.
- 118 See CMS Chief Actuary Richard S. Foster's April 22, 2010 memorandum warning about problems with CLASS: "In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. . . . his effect has been termed the 'classic assessment spiral' or 'insurance death spiral.'" (p. 15)
- 119 Permanent premium amounts, benefit amounts, and benefit triggers (disability level required to receive benefits) depend entirely on what the CLASS program can afford and still remain "actuarially solvent." The Secretary of the U.S. Department of Health and Human Services will make these critical decisions after several years of the program's results are in.
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- 129 The Patient Protection and Affordable Care Act, PPACA, or health reform, extends the “maintenance of effort” requirements indefinitely.
- 130 FMAP is the “federal medical assistance percentage,” the rate at which the federal government matches state dollars allotted to Medi-Cal.
- 131 “Maintenance of Effort/Eligibility - Not having in effect eligibility standards, methodologies or procedures under the State plan or a waiver that are more restrictive than the eligibility standards, methodologies or procedures under the plan or waiver that were in effect on March 23, 2010.” (Emphasis in the original) From: Frequently Used Terms: Patient Protection and Affordable Care Act (PPACA) & Health Care and Education Reconciliation Act of 2010; <http://www.tn.gov/nationalhealthreform/forms/frequentlyusedterms.pdf>.
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- 133 Ibid., p. 27.
- 134 Dennis G. Smith and Edmund F. Haislmaier, “Medicaid Meltdown: Dropping Medicaid Could Save States \$1 Trillion,” WebMemo, No. 2712, Heritage Foundation, December 1, 2009, p. 3, http://s3.amazonaws.com/thf_media/2009/pdf/wm2712.pdf.
- 135 For examples of reports by the author of national and state-level studies, see the Center for Long-Term Care Reform’s Web site at www.centerlrc.com, specifically <http://www.centerlrc.com/reports.htm>.
- 136 “Recovery audits allow private contractors to audit fraud in Medicaid and other programs, and collect from those cheating the system. Recovery audits are a nationally recognized best

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- 137 Because we were unable to interview or get written questions answered by Medi-Cal LTC eligibility policy specialists for this study, we repeat here the list of eligibility "leaks" we identified in a recent study of Rhode Island's Medicaid program. All are potential problems for California as well and we've added some issues unique to Medi-Cal. See Stephen A. Moses, "Doing LTC RIght," Ocean State Policy Research Institute, Providence, Rhode Island, January 2010; http://www.centerltc.com/pubs/Doing_LTC_RIght.pdf.
- 138 "As in the United States, people in Germany frequently shift or hide income and assets to qualify for welfare supplementation of their nursing home costs, according to the experts I interviewed. Unlike the U.S., Germany has a 10-year look-back or 'recapture' law under which recipients of transferred assets can be compelled to return them. No research has been done and hence no empirical data is available on how widespread artificial impoverishment to qualify for welfare-based long-term care benefits is in Germany. To raise such questions is considered 'politically incorrect,' there as here." Stephen A. Moses, "Mandatory Long-Term Care Insurance in Germany; An Enlightening Perspective," *Health Insurance Underwriter*, November 2002, pp. 30-33.
- 139 Dennis G. Smith and Edmund F. Haislmaier, "Medicaid Meltdown: Dropping Medicaid Could Save States \$1 Trillion," WebMemo, No. 2712, Heritage Foundation, December 1, 2009, p. 3, http://s3.amazonaws.com/thf_media/2009/pdf/wm2712.pdf.
- 140 TEFRA liens allow state Medicaid programs to place liens on otherwise exempt houses to secure their value for later estate recovery if—and only if—no surviving exempt dependent relative resides in the home and the Medicaid recipient has been medically determined to be unable to return to the home within six months. For a detailed explanation of Medicaid lien and estate recovery laws and regulations, see Stephen A. Moses, "Medicaid Estate Recoveries: National Program Inspection," OAI-09-86-00078, Office of Inspector General, Seattle, Washington, June 1988; <http://oig.hhs.gov/oei/reports/oai-09-86-00078.pdf>. Some of the laws and regulations governing liens and estate recoveries have changed since the publication of this report.
- 141 U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief no. 6, September 2005, <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.
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