

The Index of Long-Term Care Vulnerability: A Case Study in Georgia

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Preface

The Georgia Public Policy Foundation contracted with the Center for Long-Term Care Reform to conduct a study of Medicaid and long-term care financing in Georgia. Field work on this project began August 8, 2013, and concluded August 27, 2013, with a final report due September 30, 2013.

Stephen Moses, president of the Center for Long-Term Care Reform, interviewed 47 people with knowledge and expertise related to long-term care financing in Georgia. They included key state legislators, public officials and representatives of interest groups with stakes in long-term care service delivery and financing. Those interviewed are enumerated at the end of this report in the “List of Interviewees.” Each study participant will receive an electronic copy of this report. Anyone else may obtain a copy by request to info@centerltc.com or by downloading it from the Center’s Web site at <http://www.centerltc.com/reports.htm>.

Additional research conducted for this study by Mr. Moses included (1) a review of federal Medicaid long-term care eligibility rules as they apply in Georgia’s “income cap” eligibility system, (2) a review of Georgia’s state-specific Medicaid eligibility rules online and through interviews with Department of Human Services (DHS) eligibility staff in three counties, (3) an analysis of Medicaid planning techniques used in Georgia, (4) study of long-term care providers’ perspectives and (5) an examination of private long-term care financing alternatives such as estate recovery, home equity conversion and long-term care insurance.

Staff of Georgia’s Medicaid program, including the long-term care financial eligibility policy specialist and the person responsible for Medicaid estate recoveries in the Department of Community Health (DCH), were not interviewed; DCH declined to participate in the study due to heavy workloads.

Acknowledgements

We thank everyone who agreed to be interviewed for this study. We especially appreciate the staff of the Georgia Department of Human Services’ Division of Family and Children Services who took time away from their heavy workloads to be interviewed.

The Center for Long-Term Care Reform (www.centerltc.com) is an independent, non-partisan research institute dedicated to ensuring quality long-term care for all Americans. The Georgia Public Policy Foundation is an independent think tank that proposes practical, market-oriented approaches to public policy to improve the lives of Georgians. Nothing written here is to be construed as necessarily reflecting the views of the Center for Long-Term Care Reform Georgia or the Georgia Public Policy Foundation or as an attempt to aid or hinder the passage of any bill before the U.S. Congress or the Georgia Legislature.

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Executive Summary

Long-term care for the elderly is already a large risk and expense for private citizens and public programs. The need for and cost of long-term care will increase radically with the aging of the baby-boom generation. Most expensive long-term care, including care provided in nursing homes or by professional aides in family homes for more than nominal durations, is paid for by Medicaid, a means-tested public assistance program.

Medicaid already strains federal and state budgets, including Georgia's. Yet major initiatives at the federal level and in Georgia are under way that will expand Medicaid utilization in general and make the program's long-term care benefits more attractive and accessible. Georgia aspires to achieve those goals by further rebalancing care from mostly institutional services to mostly home and community-based services and, over time, by turning over management for more recipients with higher acuity care needs to managed care organizations.

Georgia faces multi-faceted long-term care problems, including:

- A rapidly increasing elderly population
- Higher numbers of recipients with disabilities or dementia
- A Medicaid program already strained as the principal payer for long-term care
- Dependence on funding from the heavily indebted federal government
- State revenues constrained by recessionary pressures and limited future economic prospects
- Very little private financing of long-term care to relieve the budgetary pressure on public programs
- Heavy public dependency on social programs and a growing "entitlement mentality" among the citizenry

By focusing on improving the state's current long-term care service delivery and financing program instead of taking into account this full range of problems and addressing it, Georgia runs the risk of modifying a broken system that cannot survive the larger oncoming demographic, economic and social challenges. This report offers a way to take account of these broader challenges by applying an Index of Long-Term Care Vulnerability. It recommends that Georgia reassess its current initiatives and move in the direction of reducing dependency on public programs while attracting more private revenue into the long-term care financing mix.

National Overview

Long-term care is custodial or medical assistance needed for three months or more due to an inability to perform activities of daily living independently.¹ It is expensive, whether received in a nursing home, an assisted living facility or in one's own home.² The risk of needing some form

¹ Although long-term care can be required and often is at earlier ages, this study focuses on the elderly.

² "[T]he average annual cost of care in the U.S. is \$94,170 for a private room in a nursing home; \$82,855 for a semi-private room in a nursing home; \$41,124 for an assisted living facility and; \$18,460 for adult day care. The average annual cost of care received at home was approximately \$29,640." Source: John Hancock Life Insurance Company (John Hancock) biennial long-term care (LTC) cost study, press release published July 30, 2013, http://www.johnhancock.com/about/news_details.php?fn=jul3013-text&yr=2013.

of long-term care after age 65 is 69 percent.³ The catastrophic risk of needing five years or more is 20 percent.⁴ Nevertheless, people often ignore the risk and cost of long-term care. Few save, invest or insure for the possibility of large long-term care expenses in later life.

Most people, when asked, say they believe Medicare pays for long-term care. It does not. Its sister program, Medicaid, does pay for most long-term care.⁵ Contrary to conventional wisdom, Medicaid's long-term care benefits are relatively easy to qualify for financially.⁶ Peer-reviewed research indicates that the availability of Medicaid long-term care benefits crowds out private financing and planning.⁷ Other reliable research shows that, ironically, higher-income individuals gain as much or more from Medicaid's long-term care benefits as the poor.⁸

Even as Medicaid spending grows rapidly, especially for long-term care, states are increasing Medicaid's attractiveness by "rebalancing" toward long-term services and supports (LTSS) provided in the community and away from the more traditional nursing home care. Most people prefer home and community-based services to institutional care, but the common belief that home care saves Medicaid money is dubious.⁹

Medicaid already strains state and federal budgets. Many states are about to add thousands of new recipients to Medicaid's rolls through the Affordable Care Act's program expansion. A demographic "Age Wave" is coming soon that will strain Social Security and Medicare

³ Peter Kemper, Harriet L. Komisar, and Lisa Alecxih, "Long-Term Care Over an Uncertain Future: What Can Current Retirees Expect?" *Inquiry*, Vol. 42, Winter 2005/2006, pps. 341-342, <http://www.inquiryjournal.org/>.

⁴ *Ibid.*

⁵ For a good quick overview of long-term care risk, cost and sources of financing, see David Rousseau, MPH; Jamie Firth; Anne Jankiewicz, "A Short Look at Long-term Care for Seniors," *JAMA*. 2013; 310(8):786. doi:10.1001/jama.2013.17676; <http://jama.jamanetwork.com/article.aspx?articleid=1733726>.

⁶ Income rarely interferes with Medicaid long-term care eligibility because most states subtract private medical and long-term care expenses from income before determining income eligibility and, in the rest of the states, Miller income diversion trusts allow applicants to divert excess income temporarily in order to qualify. Virtually unlimited assets are exempt including up to \$802,000 of home equity in some states and \$536,000 in other states. Also exempt under federal rules – with no limit – are income-producing businesses, one automobile, term life insurance, personal belongings, home furnishings, prepaid burial funds and Individual Retirement Accounts (IRAs), if they generate regular outlays as all are required to do after age 70 and a half. For details, see Stephen A. Moses, "Briefing Paper #2: Medicaid Long-Term Care Eligibility;" Center for Long-Term Care Reform, Seattle, Washington, 2011, <http://www.centerltc.com/BriefingPapers/2.htm>.

⁷ For example: "We examine the interaction of the public Medicaid program with the private market for long-term care insurance and estimate that Medicaid can explain the lack of private insurance purchases for at least two thirds and as much as 90 percent of the wealth distribution, even if comprehensive, actuarially fair private policies were available." Source: Jeffrey R. Brown and Amy Finkelstein, "The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market," National Bureau of Economic Research, December 2004, cited from the paper's "Abstract," http://www.nber.org/~afinkels/papers/Brown_Finkelstein_Medicaid_Dec_04.pdf.

⁸ "Richer people also get on Medicaid!" and "Richer people on Medicaid get big transfers." Source: Testimony August 1, 2013, before the federal Long-Term Care Commission by Eric French (<http://www.ltccommission.senate.gov/Eric%20French.pdf>) based on research by Mariacristina De Nardi, Federal Reserve Bank of Chicago and University College London; Eric French: Federal Reserve Bank of Chicago and University, College London; and John Bailey Jones: SUNY-Albany. Citation: Mariacristina De Nardi, Eric French, and John Bailey Jones, "Medicaid Insurance in Old Age (REVISED June 2013)," Federal Reserve Bank of Chicago, Chicago, Illinois, WP 2012-13, June 2013;

http://www.chicagofed.org/webpages/publications/working_papers/2012/wp_13.cfm.

⁹ See Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/4.htm.

immediately and Medicaid before long. Widespread Medicaid reform measures, such as rebalancing, may or may not save money, but they will make financing for Medicaid long-term care more popular and sought after. Managed care for high-risk populations may result in unavoidable problems and unanticipated costs.

Long-Term Care in Georgia

Like every state in the nation, Georgia faces an onslaught of frail and infirm elders as the demographic wave of aging baby boomers advances. But Georgia's risk is far greater than most. The state's 142,000 citizens over age 85 now will more than quadruple by 2050, a rate (375 percent) that is third highest in the nation.¹⁰ Somewhat mitigating the demographic risk, however, is the fact that long-term care costs less in Georgia compared with the national average. For example, charges for a semi-private nursing home room in the state average \$181 per day versus \$222 nationally; a private, one-bedroom apartment in assisted living runs \$3,077 per month versus \$3,550 nationally. Likewise, home health aides (\$18 per hour) and adult day care (\$64 per day) cost less in Georgia than the national averages, \$21 per hour and \$70 per day, respectively.¹¹ Georgians appear no more personally concerned about these risks and costs than other Americans. Their private long-term care insurance take up rate of 3.5 percent is well below the 4.5 percent national average for people age 40 and over who have the coverage.¹²

In Georgia, as in the rest of the country, Medicaid is the dominant payer for long-term care for the aged, spending \$784 million or 76 percent of \$1.02 billion in total for their nursing home care in 2011 and \$134 million or 13 percent on waived home and community-based services.¹³ Aged, blind and disabled recipients, the biggest users of Medicaid's long-term care services, are 29 percent of the caseload but consume 58 percent of Medicaid expenditures.¹⁴

Medicaid is already a huge and rapidly growing strain on the state's resources. Enrollment is at an all-time high of 1.8 million Georgians, covering 18.6 percent of the state's population, up from 11.6 percent in 2000. Spending for Medicaid and PeachCare now takes up 15.6 percent of state revenues, versus 10.2 percent in fiscal 2000.¹⁵ Even if Georgia does not expand Medicaid

¹⁰ Third highest after Alaska (650%) and Nevada (474%). Source: Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 7, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

¹¹ MetLife Mature Market Institute, "The 2012 MetLife Market Survey of Nursing Home, Assisted Living, Adult Day Services, and Home Care Costs," state by state "Tables," <https://www.metlife.com/mmi/research/2012-market-survey-long-term-care-costs.html#tables>.

¹² Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 103, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

¹³ "Data Source: DSS, Claims Incurred July 1, 2010 through June 30, 2011; paid through December 2011 and includes crossovers." Cited in Thompson Reuters, "Georgia Department of Community Health Aged, Blind and Disabled (ABD) Profiles," April 10, 2012, slide #13, http://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/31/55/184043468ABD_Data-%20Final.pdf.

¹⁴ Georgia Medicaid and PeachCare for Kids, presentation to the 2013 Joint Study Committee on Medicaid Reform, presented by Commissioner Clyde L. Reese III, Esq., Commissioner Jerry Dubberly, Chief Medicaid Division, August 28, 2013, slide #33.

¹⁵ Andy Miller, "Medicaid, PeachCare enrollment hits record high," *Athens Banner-Herald*,

under the Affordable Care Act, state officials anticipate large additional enrollments (61,000) and expenditures (\$156.7 million) as a result of a “woodwork effect” of new enrollees who discover they’re eligible for Medicaid.¹⁶

Can the state budget sustain such high and rapidly growing Medicaid expenditures, with a burgeoning elderly population increasingly in need of expensive long-term care services? Legislators and public officials told us Medicaid growth already impinges on other spending priorities such as education, highways and prisons. Senator Jack Hill, Chairman of the Senate Appropriations Committee, said, “We’ve taken money from things we want to do and put it into things we have to do.”¹⁷

After years of cutbacks since the “Great Recession” of 2009, state revenues are slowly turning up, but no one knows how long that will continue or whether revenue growth can keep up with population growth indefinitely. Senator Renee Unterman, Chairman of the Senate Health and Human Services Committee, opined, “Our state is different than other states. We have high population growth with less money coming in. It is imperative to do self analysis like your study.”¹⁸

Who Qualifies for Medicaid Long-Term Care in Georgia?

Medicaid is a means-tested public assistance program. Eligibility depends on applicants meeting or spending down to what appear to be draconian income and asset levels. For example, to qualify for Medicaid-financed long-term care in Georgia, individuals must have incomes of \$2,130 per month or less and countable assets of no more than \$2,000.

These low limits are misleading. Extra income can be transferred into Miller income diversion or qualified income trusts (QITs) to allow people with much higher incomes to qualify. Eligibility workers in Georgia provide templates to help applicants prepare these trusts.¹⁹ Attorneys routinely set them up for clients. Otherwise countable assets can be converted into virtually unlimited exempt assets, including up to \$536,000 of home equity plus one automobile, prepaid burial plans, personal belongings and home furnishings of unlimited value.

People too wealthy to qualify even under these relatively generous standards often consult Medicaid planning attorneys who help them reconfigure their income and assets to qualify for long-term care benefits. Common Medicaid planning techniques used in Georgia include asset transfers, promissory notes, annuities and purchase of exempt assets. An Internet search for “Medicaid planning in Georgia” reveals many examples of firms specializing in this practice.

August 30, 2013, <http://onlineathens.com/health/2013-08-29/medicaid-peachcare-enrollment-hits-record-high>.

¹⁶ Interview, August 22, 2013, with Margie M. Coggins Miller, Senior Budget and Policy Analyst, House Budget and Research Office.

¹⁷ Interview, August 21, 2013.

¹⁸ Interview, August 27, 2013.

¹⁹ Based on interviews with Medicaid eligibility workers and supervisors in Region 1 and Region 3 on August 26, 2013 and in Region 14 (DeKalb County) on August 27, 2013.

Here's one:

[T]he substantial cost of nursing home care for an incapacitated person can wipe away a family's nest egg and the inheritance planned for surviving family members. The primary alternative to privately paying the nursing home is Medicaid. ... With the help of an experienced Elder Law and Medicaid Planning attorney many of the assets you have spent a lifetime accumulating can be protected from high nursing home expenses.²⁰

The use of QITs to protect income, exemptions to protect assets and sophisticated legal techniques to divert or divest larger amounts of both varies widely by geographical area in the state. Interviews with Medicaid long-term care financial eligibility workers in rural areas of Georgia revealed relatively few such practices. About 10 percent of their long-term care cases involved QITs, compared with 35 percent in more-urban DeKalb County. Prepaid burial accounts, which workers throughout the state routinely encourage applicants to establish in order to spend down to allowable asset limits, also occurred less often in rural counties (40 percent to 50 percent of long-term care cases) than in the urban office (DeKalb) where there is “usually one for the community spouse and the institutional spouse” averaging \$10,000 but as high as \$20,000 or \$30,000.²¹ Workers interviewed in a suburban office reported that while only 25 percent of their LTC cases involved attorneys, because of their complexity those cases occupied 50 percent of their time.

Significant Medicaid planning is commonplace only in the urban office we visited (DeKalb). There, workers were very outspoken. Eighty percent of their Medicaid long-term care applicants are represented by lawyers and most of their applications are filled out and submitted by attorneys who discourage the workers from speaking to the applicants themselves. Among the practices workers cited:

- Otherwise countable real estate is put up for sale to make it exempt, but later gets transferred to another party, thus evading estate recovery.
- Annuities worth hundreds of thousands of dollars are established following Medicaid rules but with a single annual payout that prevents the state from capturing any of the money to offset Medicaid costs.
- High-income individuals who paid privately for care are allowed to set up QITs, move excess income into the trusts, then take it back out to reimburse themselves for what they spent privately before becoming eligible for Medicaid.
- Lawyers advise married applicants to claim “loss of affection” so that workers have to consider them separately and hence, more advantageously, to the lawyers’ clients.
- Promissory notes of at least \$100,000 and often much more are commonly allowed with payments to the Medicaid recipient from the note, if any, treated as income but the principal uncounted.

²⁰ Cited September 12, 2013, from the Web site at <http://www.cpyke.com/services/elder-law-medicaid-services/> of Pyke & Associates, P.C., 340 Corporate Center Court, Stockbridge, GA 30281, Phone: (770) 507-2500, information@cpyke.com.

²¹ Based on interviews with Medicaid long-term care financial eligibility workers and supervisors identified in the List of Interviewees at the end of this report.

I asked DeKalb workers: If someone has a home worth \$500,000, an unreported or for sale house out of state, and \$300,000 in assets, would he or she be eligible or easily become so? The answer was a confident “yes.”

Married applicants for Medicaid long-term care benefits get special consideration to protect the well spouse from impoverishment. Community spouses (usually a wife who remains in the home) can draw on their institutionalized spouses’ income to bring their monthly income up to \$2,898. They may retain \$115,920 of the couple’s joint assets. Excess income goes to offset Medicaid’s cost of care and excess assets must be divested, diverted, exempted or spent down before eligibility is granted.

Georgia’s financial eligibility standards for individual applicants are relatively strict, *e.g.*, the state has an “income cap” system instead of the more lenient “medically needy” income eligibility system used by most states. Interestingly, however, Georgia’s policy with regard to married applicants is more generous than most states. Federal law allows and most states do place stricter limits on the minimum monthly maintenance needs allowance (\$2,184 plus a housing allowance up to a possible \$2,898 limit) and the community spouse resource allowance, or CSRA (half the joint assets *not to exceed* \$115,920). But Georgia generously treats the federal maximum allowance and CSRA as both its maximum and minimum, allowing community spouses to retain full MMMNA and CSRA whether or not they have housing expenses or joint assets double the CSRA limit.

Maintenance of Effort

No state has been able to tighten Medicaid financial eligibility rules since 2009. The American Recovery and Reinvestment Act of that year gave states substantial federal matching fund bonuses to help them adjust to declining revenue and growing caseloads caused by the Great Recession.²² These bonuses were conditional upon states *not* restricting eligibility more than was the case prior to enactment. When the Affordable Care Act became law on March 23, 2010, it extended the restriction on tightening eligibility but halted the bonus matching funds.

Georgia Medicaid backed off from several earlier plans to reduce eligibility as a consequence of the restriction. When budgetary problems were at their worst after the recession, with eligibility off the table, the state had only two remaining tools to control Medicaid expenditures: Cut services or cut provider reimbursements. Georgia’s optional Medicaid services are already among the least generous in the country and its provider reimbursement levels are low as well.

Cutting services hurts the poor especially and cutting reimbursements can damage care quality. Reducing financial eligibility for long-term care services so that more prosperous recipients would need to spend more of their own money for their care would have been the least onerous way to deal with budget shortfalls. But the restriction on tightening eligibility meant such changes were not available options and remain off the table, even though they are due to expire January 1, 2014.

²² Wikipedia, “American Recovery and Reinvestment Act of 2009,” http://en.wikipedia.org/wiki/American_Recovery_and_Reinvestment_Act_of_2009.

Rebalancing and Managed Care

Georgia has already “rebalanced” its Medicaid long-term care program from mostly nursing home care to nearly half (48 percent) home- and community-based care.²³ It has therefore made Medicaid long-term care more attractive as a long-term care funding source and delivery system. The state continues to do more of the same.

But Georgia has done less planning to prepare for the reality that a huge new older generation will soon flood the state’s social programs, of which Medicaid long-term care is one of the most expensive, or to restrict the relatively easy financial eligibility for the program described previously.

The state has already implemented a managed care system for most of its recipients (low-income women and children) and intends to implement managed care for the aged, blind and disabled. People eligible for both Medicaid and Medicare (dual eligibles) may in time be included in the managed care program, although there has been some political pushback from that objective. Managing preventive and acute care of low-income women and children has generated substantial savings to Medicaid, but there is serious concern that similar savings may be unachievable without negatively impacting the access to and quality of care for frail and chronically ill elderly people.

Long-Term Care Providers’ Perspective

The biggest challenge to long-term care providers in Georgia is adequate and predictable Medicaid reimbursement while providing high quality services. According to interviewees, affluent families often supplement Medicaid payments to ensure more or better services for their loved ones, a practice called “family supplementation.” This practice was prohibited formerly in order to ensure equal care under Medicaid for all, regardless of how wealthy some recipients’ families might be. Any supplemental income provided on behalf of a Medicaid recipient was treated as extra income to be applied to offset Medicaid’s cost of care, not to purchase extra benefits beyond what Medicaid covers. Permitting family supplementation is another way, besides the Medicaid planning techniques discussed above, that affluent people can take advantage of a program originally intended as a safety net for the poor.

The proportion of Georgia’s nursing home residents who depend on Medicaid as their primary payer has declined in the past decade from 83 percent to 72 percent. As lighter care patients were diverted into home- and community-based services, nursing home caseloads increased in acuity of care and declined in duration of stay. Nursing homes turned increasingly to sub-acute and rehabilitative care paid by Medicare far more generously than traditional Medicaid financing for custodial care. Higher Medicare reimbursements have helped to balance losses from lower Medicaid payments, but federal budget challenges threaten that arrangement as proposals to cut Medicare reimbursements to skilled nursing facilities increase and gain more serious

²³ Source: Interview on August 23, 2013 with Richard E. Dunn, Director, Health and Human Services Division, Governor’s Office of Planning and Budget and Blake T. Fulenwider, Health Reform Administrator, Governor’s Office of Planning and Budget.

consideration. Private payers, who also pay higher rates than Medicaid, have declined radically in number and proportion as well.

Nursing home operators interviewed for this study said they could not operate solely on Medicaid funding. “Medicare and private insurance are where our margins are and that’s getting skinnier and skinnier.”²⁴ The “private insurance” they refer to includes Medicare supplemental insurance, Medicare Advantage coverage, and other health insurance, not private long-term care insurance, which they see in only 1 percent or 2 percent of their admissions.

Medicaid-financed home and community-based services present a special problem. Georgia does not offer personal care as an optional service under the state plan. Such services are available only under waived programs for which slots are capped, resulting in waiting lists. Financial eligibility for these services is tougher than for nursing home care, which means people who cannot afford \$21 to \$26 per hour for private home care may have Medicaid nursing home care as their only viable option.²⁵ Assisted living, which is an in-between alternative in more and more states, is not an option in Georgia. The state recently created an official assisted living level of care for the first time, but it excludes providers with fewer than 25 beds and does not allow Medicaid reimbursement.

Private Long-Term Care Financing

There are four ways in which the pressure on Medicaid to finance long-term care could be relieved by additional private financing, none of which figure prominently in Georgia.

1. Asset spend down: As explained previously in the section on Medicaid long-term care financial eligibility, relatively easy income and asset rules – most of which are mandated by federal law and regulation – make access to Medicaid-financed long-term care attainable for most applicants without significant expenditure of private funds. The home equity exemption of \$536,000 in Georgia (up to \$802,000 in 13 other states) is a major factor, but Medicaid planning techniques of artificial self-improvement also contribute substantially. On the one hand, middle class and affluent people believe they should not be excluded from public long-term care benefits simply because they were responsible citizens who accumulated adequate retirement income and savings. Therein lies the political sensitivity of the issue. But, on the other hand, how does anyone benefit if public programs prove inadequate to fund access to quality care in appropriate venues of care for everyone, poor and rich alike?

2. Estate recovery: Arguably, if Medicaid allows people to retain substantial wealth while receiving publicly financed long-term care benefits, they ought to reimburse Medicaid for the cost of their care out of their estates. Otherwise, Medicaid operates as free inheritance insurance for their heirs. That was the principle embodied in the Omnibus Budget Reconciliation Act of 1993, which made Medicaid estate recovery mandatory as a condition of receiving any federal matching funds for the program. Georgia did not implement an estate recovery program for more

²⁴ Interview August 21, 2013 with Jerry Patton, L.N.H.A., CHC, Chief Operating Officer, A.G. Rhodes and Greg Heath, Administrator, A.G. Rhodes Health & Rehab, A.G. Rhodes of Wesley Woods.

²⁵ Source: Interview August 19, 2013 with Catherine Ivy, Executive Director, NASW Georgia Chapter, Atlanta, Georgia.

than a decade after it was required and the federal government did not compel it to do so. The state does have a program now, operated by a private contractor. But Georgia's program excludes the first \$25,000 of an estate from recovery. Our requests to interview the state official or contractor representative responsible for estate recoveries were not granted, so data on Georgia's actual estate recoveries were not available. Given that the average estate recovery in successful states is well below \$25,000, it is highly doubtful that Georgia is maximizing non-tax revenue from this source. The federal government has not published state-level data on estate recoveries since 2005, at which time Georgia recovered nothing.²⁶ The author recently published a report detailing collections and listing best practices in leading estate recovery states titled, "Maximizing Non-Tax Revenues from MaineCare Estate Recoveries."²⁷

3. Home equity conversion: The single biggest asset aging people possess is their homes. Over two-thirds of Georgians (66.8 percent) own their homes, which have a median value of \$160,200. In the absence of Medicaid's home equity exemption – \$536,000 in Georgia – many more people would use their home equity to pay for long-term care before becoming dependent on Medicaid. Reverse mortgages enable people age 62 and over to extract equity from their homes while continuing to live in them. That extra money could be used to fund home- and community-based services privately. But the reverse mortgage option ends where mobility, morbidity or mortality begins. Such mortgages become due and payable when the elder mortgagee becomes too ill to remain, moves out, dies or sells. Alternatively, families who want to retain the elders' home could pitch in to help pay for home care, assisted living or nursing facility care, providing in essence an informal family-based reverse mortgage.

Many variations would be possible, but current public policy exempting a huge amount of home equity discourages all such options from a purely financial standpoint. There are other reasons, however, to consider home equity conversion for funding long-term care. As one of our interviewees said in her "elevator speech" about reverse mortgages, "If you take a reverse mortgage to pay for your long-term care instead of qualifying for Medicaid, it gives you ultimate consumer control. You get to purchase as much or as little as you need, which is very difficult to do under Medicaid. You can pay a neighbor to bring your dinner. It helps you maintain as much as you can of your dignity and independence."²⁸

4. Private long-term care insurance: Private long-term care insurance market penetration in Georgia is minimal: 3.5 percent of the age 40-plus population compared with 4.5 percent nationally.²⁹ According to experts at the Georgia insurance commission, 56 carriers reported 162,575 long-term care policies in force in the state as of December 31, 2012. The number of carriers actively marketing such insurance in Georgia has plummeted from 50 or 60 with

²⁶ 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>.

²⁷ Stephen A. Moses, "Maximizing Non-Tax Revenues from MaineCare Estate Recoveries," Center for Long-Term Care Reform, Seattle, Washington and the Maine Heritage Policy Center, Portland, Maine, 2013, <http://www.centerltc.com/pubs/Maine2013.pdf>.

²⁸ Interview August 19, 2013 with Catherine Ivy, Executive Director, NASW Georgia Chapter, Atlanta, Georgia.

²⁹ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 103, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

products approved five or six years ago. Today, only 20 carriers have policies certified to participate in Georgia's Long-Term Care Partnership Program. That program encourages the purchase of long-term care insurance by granting purchasers of partnership policies who actually use their benefits a forgiveness of Medicaid's spend down requirement equal to the amount of coverage used. For example, a beneficiary who collected \$100,000 in benefits from a partnership-qualified policy would be able to qualify for Georgia's Medicaid long-term care benefits while retaining \$102,000 in otherwise countable assets instead of the usual \$2,000 limit. Interviewees representing the long-term care insurance industry said Georgia has not promoted its Long-Term Care Partnership program and the market for private long-term care insurance in general is flat or declining. A discussion of the many factors inhibiting the market for private long-term care insurance, including lower lapse and interest rates than expected and higher claims, is beyond the scope of this paper. But it is appropriate to observe that demand for private insurance protection against the risk and cost of long-term care might be considerably greater if Medicaid long-term care benefits were not so easy to obtain after the insurable event occurs.

Outlook

Given the current status and likely development of Georgia's long-term care service delivery and financing system as described above, what are its likely prospects for sustainability in the future? How vulnerable is the system to future demographic, economic and social shocks? Following is a proposed method to answer those questions in any state and an application of the method specifically to Georgia.

Long-Term Care Analysis

Much scholarly effort goes into studying problems related to the aging of America. Long-term care is a major target of such research. But long-term care has many complicated components, such as risk, cost, care giving, service delivery and financing. These factors are impacted by many related issues such as public awareness, the economy's health, government budgets, personal savings and available financial products. Usually, these components and issues are examined one by one or in small groups, rarely altogether. They are studied in silos rather than comprehensively.³⁰

The question most commonly asked is, "How can we fix or improve such and such a problem or program?" Unfortunately, many scholars approach the impending long-term care crisis by describing the status quo and proposing improvements. That often leads them to recommend more public financing. But what if public financing of long-term care has caused or exacerbated many of the service delivery and financing problems we face by discouraging responsible planning by private individuals and families? I have answered that question and developed that theme in a paper titled, "The History of Long-Term Care Financing, or How We Got Into This Mess."³¹

³⁰ For a fuller development of this theme, see Stephen A. Moses, "Opinion: The Elephant, the Blind Men, and Long-Term Care," National Underwriter LTC E-Wire, Vol. 2, No. 3, February 2003, <http://www.centerltc.com/pubs/Articles/Elephant.htm>.

³¹ Stephen A. Moses, "The History of Long-Term Care Financing, or How We Got Into This Mess," Center for Long-Term Care Reform, Seattle, Washington, 2011, <http://www.centerltc.com/BriefingPapers/1.htm>.

This report takes a different approach and asks a different question: Is the current long-term care service delivery and financing system sustainable over time in its current form or in its most likely modifications? Or put differently: How vulnerable is long-term care to the vicissitudes of aging demographics, limited financing sources and consumers' denial of risk? If we keep doing what we've always done (heavy public financing), will we get a different result, and if not, could the dominantly-government-financed long-term care system collapse catastrophically? And if so, shouldn't we consider a fundamentally different approach to long-term care service delivery and financing?

The Index of Long-Term Care Vulnerability

To answer those questions, I propose to look closely at the following variables individually and in combination, based on national data and state-level data in a series of state-specific papers:

1. How many older people are coming in the next few decades?
2. How sick will they be?
3. How viable is Medicaid as a long-term care payer?
4. How reliable is federal revenue on which Medicaid mostly depends?
5. How reliable is state revenue on which Medicaid secondarily depends?
6. How much private-pay revenue is available to relieve long-term care financing pressure on Medicaid?
7. How strong is dependency on public programs (*i.e.*, the entitlement mentality)?

With clear answers to these questions, it should be possible to predict, or at least estimate, the outcome of current and likely long-term care service delivery and financing policies. Fortunately, we have a lot of data and analysis readily available to answer these questions.³² So, we shall address them one by one. Thereafter we can array the questions and answers in a "Table of Long-Term Vulnerability," apply weights and scores, and thereby estimate the national and state-by-state sustainability of existing and likely future service delivery and financing systems. A blank copy of the "Table of Long-Term Vulnerability" and one filled out by the author are included as embedded Excel worksheets below.

1. How many older people coming?

This is the question of aging demographics. People 85 years of age and older are most likely to require long-term care. According to AARP, a good "barometer for the potential demand for long-term services and supports is the growth in the population age 85 and older, which is expected to increase by 69 percent between 2012 and 2032 and more than triple (+224 percent) between 2012 and 2050. People age 85 or older not only have much higher rates of

³² Note that data included in the Table of Long-Term Care Vulnerability may not correspond exactly with data supplied earlier in this report, which were based on current state-specific information. The reason for such possible discrepancies is that we have drawn on data sources for the Index of Long-Term Care Vulnerability, which provide information that is consistent across all states but which may not be as current. This was necessary to make possible comparisons of long-term care vulnerability across states.

disability, but they are also much more likely to be widowed and without someone to provide assistance with daily activities.”³³

<u>People age 85+</u>	<u>United States</u> ³⁴	<u>Georgia</u> ³⁵
Number in 2012	6,426,000 (2.0%)	142,000 (1.4%)
2012 to 2032 increase	69%	121%
2012 to 2050 increase	224%	375%

Georgia is one of only seven states in which the age 85-plus population is projected to more than quadruple between 2012 and 2050.³⁶

A state’s long-term care vulnerability is higher if its age 85-plus population growth is higher than the national average.

2. How sick are they?

This question bears on the aging population’s health condition. The proportion of people age 65-plus with disabilities and the number of long-term care facility residents with dementia (a major cause of long-term care) factor critically into the consideration of how likely the aging population is to need and receive long-term care.

	<u>United States</u> ³⁷	<u>Georgia</u> ³⁸	<u>Rank</u> ³⁹
People age 65+ with disabilities, 2010:			
a. Self-care difficulty	8.8%	9.7%	9
b. Cognitive difficulty	9.5%	11.1%	7
c. Any disability	37%	40.0%	11
Nursing facility residents with dementia, 2010	46% ⁴⁰	49.0%	17 ⁴¹

Georgia’s population age 65-plus with disabilities is high compared with the rest of the country. The state’s proportion of nursing facility residents with dementia is also high compared with the national average.

³³ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 7, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

³⁴ *Ibid.*, p. 36.

³⁵ *Ibid.*, p. 102.

³⁶ “The age 85+ population is projected to more than quadruple in seven states between 2012 and 2050: **Alaska** (+650%), **Nevada** (+474%), **Georgia** (+375%), **Colorado** (+369%), **Utah** (+323%), **Texas** (+318%), and **Virginia** (+307%).” *Ibid.*, p. 7.

³⁷ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 37; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

³⁸ *Ibid.*, p. 103.

³⁹ *Ibid.*

⁴⁰ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 40; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁴¹ *Ibid.*, p. 106.

A state's long-term care vulnerability is higher if it has more people age 65-plus with disabilities and more nursing facility residents with dementia.

3. How viable is Medicaid as a long-term care payer?

Because Medicaid is the dominant payer for high-cost long-term care in the United States, its current status and likely future viability factor vitally into the question of whether or not the long-term care system now in place can survive. Medicaid's long-term care viability breaks down into several sub-factors.

<u>Expenditure trends</u>	<u>United States</u>	<u>Georgia</u>	<u>Rank</u>
Percent of budget for Medicaid ⁴²	23.7%	20.5%	
Medicaid LTSS spending change for older people and adults with physical disabilities 2004 to 2009	+28% ⁴³	+0%	46th ⁴⁴
Medicaid nursing facility spending change 2004 to 2009	+12% ⁴⁵	-15%	50th ⁴⁶
Medicaid HCBS spending change for older people and adults with physical disabilities 2004 to 2009	+70% ⁴⁷	+109%	10th ⁴⁸
Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities 2004-2009	+9% ⁴⁹	+13%	7th ⁵⁰
Federal Medical Assistance Percentage (FMAP)	50% ⁵¹	66% ⁵²	

⁴² *State Health Facts*, The Henry J. Kaiser Family Foundation, "Distribution of State General Fund Expenditures," <http://kff.org/other/state-indicator/distribution-of-general-fund-spending/>.

⁴³ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 107; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

⁵¹ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," <http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>.

⁵² *Ibid.*

Georgia spends a somewhat lower percentage of its state budget on Medicaid when compared with the national average. The states' long-term care spending for older people and adults with physical disabilities remained flat for five years despite a relatively high (70 percent) increase in spending on home- and community-based care, apparently because of an unprecedented 15 percent drop in nursing facility spending. Georgia's rebalancing from institutional to home- and community-based care is advancing without increasing total LTC expenditures. With a high Federal Medical Assistance Percentage (FMAP) approaching two-thirds, Georgia is well positioned to maximize federal revenue.

A state's long-term care vulnerability is higher if its rate on the preceding factors (except FMAP) is higher than the national rate. A higher FMAP indicates a state's lower economic prosperity, but it is a positive factor because it means the state can garner more federal funds from the same investment of state funds. Expanded spending on home- and community-based care is deemed a negative factor because it makes Medicaid a more attractive long-term care payer, and discourages private home care financing, private long-term care savings or insurance and free care provided by families, friends or charities.⁵³

<u>Other Medicaid sub-factors</u>	<u>United States</u>	<u>Georgia</u>
Medicaid expansion under ACA?	25 yes; 22 no 4 undecided ⁵⁴	No as of 9/10/13
Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy)	Easy ⁵⁵	Easy
Low reimbursement vulnerability (shortfall per Skilled Nursing Facility bed day, 2012 projected)	(\$22.34) ⁵⁶	(\$12.48) ⁵⁷
Cost shifting: Medicaid nursing home rate as percentage of private pay rate	92.2% ⁵⁸	89.4% ⁵⁹

On Medicaid expansion under the Affordable Care Act, Georgia "is not moving forward at this time."⁶⁰ The state's Medicaid long-term care financial eligibility is relatively strict in

⁵³ For further explanation, see Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/4.htm.

⁵⁴ Cited as of September 3, 2013. *State Health Facts*, The Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013," <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁵⁵ See footnote #8 for why Medicaid LTC financial eligibility is relatively "easy."

⁵⁶ "A Report on Shortfalls in Medicaid Funding for Nursing Center Care," ELJAY, LLC for the American Health Care Association, December 2012, p. 1, http://www.ahcancal.org/research_data/funding/Documents/FINAL%20Medicaid%20Underfunding%20for%20Nursing%20Home%20Care%20Report.pdf.

⁵⁷ *Ibid.*, p. 8.

⁵⁸ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 39; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

Based on a Medicaid rate of \$178 and a private-pay rate of \$193.

⁵⁹ *Ibid.*, p. 105. Based on a Medicaid rate of \$143 and a private-pay rate of \$160.

some ways (income cap), but relatively lenient in other ways (spousal impoverishment); details previously in the section on eligibility. Nursing facilities in Georgia operate at a loss for their Medicaid residents, but that loss is not as large as the national average. The disparity between Georgia's Medicaid nursing home reimbursement rate and the average private-pay rate is close to the national average.

A state's long-term care vulnerability is higher if:

- (1) It expands Medicaid under the Affordable Care Act
- (2) Its financial eligibility for Medicaid long-term care benefits is more lenient
- (3) Its nursing home reimbursement shortfall is higher, or
- (4) Its Medicaid institutional reimbursement rate is lower compared with its private-pay rate.

Federal Medicaid long-term care financial eligibility is deemed "easy" because income rarely obstructs eligibility, exempt assets are practically unlimited and artificial self-impoverishment through legal Medicaid planning techniques is readily available.⁶¹

<u>Dual eligibles vulnerability</u> ⁶²	<u>United States</u>	<u>Georgia</u>
Dual eligibles as share of all Medicaid enrollees	15% ⁶³	16% ⁶⁴
Duals as share of all aged and disabled enrollees	60% ⁶⁵	62% ⁶⁶
Dual eligibles spending as % of total Medicaid	39% ⁶⁷	32% ⁶⁸

Compared to the nation as a whole, Georgia has a slightly higher percentage of dual eligibles among Medicaid recipients in general and among aged and disabled recipients specifically, but the state's proportion of Medicaid spending on dual eligibles is substantially below the national average.

⁶⁰ Cited as of September 10, 2013. *State Health Facts*, The Henry J. Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision, as of September 3, 2013," <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁶¹ For details, see footnote #8 and Stephen A. Moses, "Briefing Paper #2: Medicaid Long-Term Care Eligibility," Center for Long-Term Care Reform, Seattle, Washington, <http://www.centerltc.com/BriefingPapers/2.htm>.

⁶² The nine million elderly or disabled individuals eligible for both Medicare and Medicaid are by far the most expensive beneficiaries of both programs costing \$250 billion in 2009 for health care benefits. Source: Congressional Budget Office, "Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies," June 2013, p. 1, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44308_DualEligibles.pdf

⁶³ Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton, "Medicaid's Role for Dual Eligible Beneficiaries," The Henry J. Kaiser Family Foundation, April 2012, Table 2: Dual Eligibles and Full Dual Eligibles by State, 2008, p. 5, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf>.

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ Katherine Young, Rachel Garfield, MaryBeth Musumeci, Lisa Clemans-Cope, and Emily Lawton, "Medicaid's Role for Dual Eligible Beneficiaries," The Henry J. Kaiser Family Foundation, April 2012, Table 4a Medicaid Expenditures for Dual Eligibles by State, 2008, p. 8, <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7846-03.pdf>

⁶⁸ *Ibid.*, p. 8.

A state's long-term care vulnerability is higher if it has more high-cost dual eligibles and higher spending for dual eligibles.

<u>Rebalancing vulnerability</u>	<u>United States</u>	<u>Georgia</u>	<u>Rank</u>
Family Caregivers per 1,000	137 ⁶⁹	139 ⁷⁰	23 ⁷¹
Value in Millions per 1,000	\$1,460 ⁷²	\$1,330 ⁷³	40 ⁷⁴
Ratio of value of family caregiving to state's total long-term care spending	3.8 ⁷⁵	6.6 ⁷⁶	5 ⁷⁷

Georgia has a larger proportion of family caregivers than the national average, but the value they contribute is relatively low. Nevertheless, the value of family caregiving in Georgia compared to the state's Medicaid long-term care spending is very high, ranking Georgia number five in the country.

A state's long-term care vulnerability is higher if it has fewer "free" family caregivers or lower family caregiving value contributed toward providing services.⁷⁸ Rebalancing also tends to increase overall Medicaid expenditures for long-term care, but these cost factors were captured under "expenditure trends" above.⁷⁹

<u>Managed care vulnerability</u>	<u>United States</u>	<u>Georgia</u>
Managed care for aged, blind and disabled recipients?	Expanding	No ⁸⁰
Managed care for "dual eligibles"?	Expanding	No

⁶⁹ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 103; <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁷⁰ *Ibid.*

⁷¹ *Ibid.*

⁷² *Ibid.*

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*

⁷⁸ "Americans should expect an enormous shortage in caregivers for older people in the coming decades, with a dearth of friends and family members available to care for the baby-boom generation as it ages, according to a report released Monday by AARP." Source: Tara Bahrapour, "Huge shortage of caregivers looms for baby boomers, report says," *The Washington Post*, August 5, 2013, http://www.washingtonpost.com/national/health-science/huge-shortage-of-caregivers-looms-for-baby-boomers-report-says/2013/08/25/665fb2aa-0ab1-11e3-b87c-476db8ac34cd_story.html.

⁷⁹ For details, see Stephen A. Moses, "Briefing Paper #4: Rebalancing Long-Term Care," Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerltc.com/BriefingPapers/4.htm.

⁸⁰ "ABD is referred to as 'unmanaged' meaning there is no care coordination or utilization management." Source: Georgia Medicaid and PeachCare for Kids, presentation to the 2013 Joint Study Committee on Medicaid Reform, presented by Commissioner Clyde L. Reese III, Esq., Commissioner Jerry Dubberly, Chief Medicaid Division, August 28, 2013, slide #63.

A state's long-term care vulnerability is higher if it is expanding managed care to higher acuity long-term care recipients, especially the dual eligibles.⁸¹

4. How reliable is federal revenue on which Medicaid mostly depends?

	<u>United States</u>	<u>Georgia</u>	<u>Rank</u>
Total Medicaid spending (2009) ⁸²	\$368,330M	\$7,461M	14
Five year % increase (2004-2009) ⁸³	29%	-16%	51
Federal and state shares of Medicaid ⁸⁴	63.7% - 36.3%	29.4%	
Dependency on "provider taxes" ⁸⁵	Every state but Alaska ⁸⁶	3 taxes 1+ over 3.5% ⁸⁷	
Social Security role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ⁸⁸	\$23.1 trillion ⁸⁹	Vulnerable ⁹⁰	
Medicare role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ⁹¹	\$43.0 trillion ⁹²	Vulnerable ⁹³	

⁸¹ See Judith Soloman, "Moving 'Dual Eligibles' Into Mandatory Managed Care and Capping Their Federal Funding Would Risk Significant Harm to Poor Seniors and People With Disabilities," Center on Budget and Policy Priorities, Washington, DC, October 10, 2012, <http://www.cbpp.org/files/10-10-12health.pdf> and Stephen A. Moses, "Briefing Paper #5: Dual Eligibles and Long-Term Care: How to Save Medicaid LTC \$30 Billion Per Year and Pay for the 'Doc Fix,'" Center for Long-term Care Reform, Seattle, Washington, 2011, www.centerlrc.com/BriefingPapers/5.htm.

⁸² Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 107, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

⁸³ *Ibid.*

⁸⁴ *State Health Facts*, The Henry J. Kaiser Family Foundation, "Federal and State Share of Medicaid Spending," <http://kff.org/medicaid/state-indicator/federalstate-share-of-spending/>.

⁸⁵ To raise extra state funds in order to leverage up more federal Medicaid funds, all states but Alaska tax medical and long-term care providers. States may or may not reimburse providers for such "taxes." Provider taxes are highly vulnerable to cuts: "Recent federal deficit reduction discussions have suggested gradually lowering the safe harbor threshold from 6.0 percent to 3.5 percent of net patient revenues. States have indicated that nearly 6 in 10 provider taxes currently in use by states are above that threshold." Source: The Henry J. Kaiser Family Foundation, "Quick Take: Medicaid Provider Taxes and Federal Deficit Reduction Efforts," January 10, 2013, <http://kff.org/medicaid/fact-sheet/medicaid-provider-taxes-and-federal-deficit-reduction-efforts-2/>.

⁸⁶ *Ibid.*

⁸⁷ *Ibid.* Georgia has three provider taxes of which at least one exceeds the 3.5% net patient revenue threshold so is vulnerable to a cut previously proposed.

⁸⁸ Although Social Security does not pay directly for long-term care, Medicaid does require long-term care recipients to contribute most of their income, including Social Security benefits, to offset the cost of their care. If and when Social Security needs to cut back benefit payments by 24 percent as it has warned, some of the extra cost will fall directly on state Medicaid programs and long-term care providers.

⁸⁹ Laurence Kotlikoff, "Why the Government Needs to Budget over the Infinite Horizon," *Yahoo! Finance*, June 13, 2013, <http://finance.yahoo.com/blogs/the-exchange/why-government-needs-budget-over-infinite-horizon-002610882.html>.

⁹⁰ Potential cuts to Social Security benefits would not hurt Georgia Medicaid recipients who have to contribute most of their income to offset Medicaid's cost for their care. Rather, such cuts would reduce patient revenue to long-term care providers thus reducing their reimbursement and/or increasing Medicaid's expenditures.

Federal debt⁹⁴

\$16.7 trillion⁹⁵

Highly
Vulnerable⁹⁶

Georgia has controlled Medicaid expenditures remarkably well, but the state is heavily dependent on provider taxes, which are very vulnerable to federal government cutbacks. Social Security benefit reductions or decreases in Medicare long-term care provider reimbursement levels would severely impact Georgia's ability to fund its long-term care safety net, as would any deficit-related federal revenue retrenchment.

On average, nearly two-thirds of Medicaid spending comes from federal financing. Therefore, a state's long-term care vulnerability is higher if it is relatively more dependent on federal funds.

5. How reliable is state revenue on which Medicaid secondarily depends?

Overview

State economies must generate sufficient revenue to support long-term care financing.

"State revenues in 2013 are up 5.3 percent from this time last year, but state officials are worried the gains will dissipate in 2014 ... State revenues in the current fiscal year got a boost from taxpayers who accelerated tax payments on their capital gains to avoid any fallout from the impending 'fiscal cliff.'"⁹⁷

⁹¹ Medicare does not pay directly for long-term care as its benefits are mostly limited to short-term sub-acute care and rehabilitation. Nevertheless, Medicare does pay much more generously than Medicaid for skilled nursing care and home care. Long-term care providers depend heavily on higher Medicare reimbursements to offset their losses on Medicaid. Cuts to Medicare nursing home reimbursements which are frequently proposed by the Medicare Payment Advisory Commission (MedPAC) would be devastating to Medicaid long-term care providers.

⁹² John C. Goodman and Laurence J. Kotlikoff, "Medicare by the Scary Numbers," *Wall Street Journal*, June 24, 2013, <http://online.wsj.com/article/SB10001424127887323393804578555461959256572.html>. Actually, Medicare's unfunded liability may be much worse: "Looking indefinitely into the future, the unfunded liability is \$43 trillion-almost three times the size of today's economy. Based on more plausible assumptions, such as those reflected in the 'alternative' scenario for Medicare produced by the Congressional Budget Office in June 2012, the long-term shortfall is more than \$100 trillion."

⁹³ Reduction in or loss of Medicare's currently generous long-term care reimbursement rates would impact providers severely and immediately, possibly causing withdrawals from Medicaid participation and/or closures.

⁹⁴ "In 2013, federal spending approached \$3.5 trillion and the deficit dropped to 'only' \$642 billion. Some are using this small improvement in the nation's fiscal situation to avoid further budget tightening. But as the figures and graphics in this report show, this is the wrong conclusion to draw. Following four years of trillion-dollar deficits, the national debt will still reach nearly \$17 trillion and exceed 100 percent of gross domestic product (GDP) at the end of the year." Source: Romina Boccia, Alison Acosta Fraser and Emily Goff, "Federal Spending by the Numbers, 2013: Government Spending Trends in Graphics, Tables, and Key Points," Special Report #140 on Budget and Spending, Heritage Foundation, Washington, DC, August 20, 2013, <http://www.heritage.org/research/reports/2013/08/federal-spending-by-the-numbers-2013>.

⁹⁵ U.S. National Debt Clock as of September 9, 2013, http://www.brillig.com/debt_clock/.

⁹⁶ Georgia's relatively high Federal Medical Assistance Percentage makes the state more vulnerable than some others to federal revenue sharing cutbacks.

⁹⁷ Maggie Clark, "States Pessimistic About Revenues In 2014," *Stateline*, August 13, 2013, <http://www.pewstates.org/projects/stateline/headlines/states-pessimistic-about-revenues-in-2014->

“Five years after the 2008 financial crisis sent the U.S. economy into a tailspin, only a handful of states are charging full steam ahead.”⁹⁸

“The effects of the worst economic downturn since the Great Depression are forcing changes on state governments and the U.S. economy that could linger for decades.”⁹⁹

State Specific

“Rich States, Poor States: Economic Competitiveness Index” ¹⁰⁰		<u>Georgia Rank</u>
Economic Performance Rank	From Wyoming #1 to Michigan #50	33
Economic Outlook Rank	From Utah #1 to New York #50	10
<i>Forbes</i> Best States for Business and Careers ¹⁰¹	From Utah #1 to Maine #50	8
“Fiscal Policy Report Card,” ¹⁰² Grades state Governors from A to F on their fiscal policies	From Sam Brownback (R), Kansas, score 69, A to Pat Quinn (D), Illinois, score 16, F	Nathan Deal (R), score 53, grade C
Mercatus “Freedom Index” ¹⁰³ Combined personal/economic rank; change from 2009	From #1, North Dakota; +4 To #50, New York; 0% change	#9, +11

85899497318?utm_campaign=2013-08-14-stateline-daily.html&utm_medium=email&utm_source=Eloqua&elq=f72a55085fe642ada6d8aaa930074ae0&elqCampaignId=146.

⁹⁸ Pamela M. Prah, “Five Years After Crash, States Still Picking Up Pieces,” *Stateline*, September 4, 2013, http://www.pewstates.org/projects/stateline/headlines/five-years-after-crash-states-still-picking-up-pieces-85899502301?utm_campaign=2013-09-04-Stateline-Daily.htm&utm_medium=email&utm_source=Eloqua.

⁹⁹ Jake Grovum, “Lasting Effects from Financial Crash Mean New Normal in States,” *Stateline*, September 5, 2013, http://www-origin.pewstates.org/projects/stateline/headlines/lasting-effects-from-financial-crash-mean-new-normal-in-states-85899502664?utm_campaign=2013-09-05-Stateline-Daily.htm&utm_medium=email&utm_source=Eloqua#sthash.kTZm0rQ7.s1AiAodc.dpuf.

¹⁰⁰ Arthur B. Laffer, Stephen Moore, and Jonathan Williams, *Rich States, Poor States: ALEC-Laffer State Economic Competitiveness Index*, Table 15: ALEC-Laffer State Economic Outlook Rankings, p. 56 and 2012 and Table 16: ALEC-Laffer State Economic Performance Rankings, 2000-2010, p. 57, American Legislative Exchange Council, 2012, http://www.alec.org/docs/RSPS_5th_Edition.pdf.

¹⁰¹ “The Best States for Business and Careers,” *Forbes*, December 2012, <http://www.forbes.com/best-states-for-business/list/>.

¹⁰² Chris Edwards, “Fiscal Policy Report Card on America's Governors, 2012,” Cato Institute, Washington, DC, Table 1: Overall Grades for the Governors, pps. 3-4, 2012, <http://www.cato.org/pubs/wtpapers/GRC2012.pdf>. “This report grades governors on their fiscal policies from a limited-government perspective. The governors receiving an ‘A’ are those who cut taxes and spending the most, while the governors receiving an ‘F’ raised taxes and spending the most. The grading mechanism is based on seven variables, including two spending variables, one revenue variable, and four tax rate variables.” (p. 3)

¹⁰³ Mercatus Center, “Freedom in the 50 States,” list view, <http://freedominthe50states.org/>.

Tax Foundation ¹⁰⁴	U.S. Average: 9.9%;	9.0%, #33
State-Local Tax Burden	Range: #1, New York, 12.8% to #50, Alaska, 7.0%	

State Budget Shortfalls (2013) ¹⁰⁵	30+DC Yes	Yes, \$300M
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Georgia's economic prospects are positive despite a relatively low performance ranking and Governor's grade.

A state's long-term care vulnerability is higher if it ranks lower on these measures of economic performance, outlook, business climate, freedom and budget.

6. How much private pay is available to relieve long-term care financing pressure on Medicaid?

	<u>United States</u>	<u>Georgia</u>
Asset spend down potential ¹⁰⁶	Higher if easy eligibility can become less easy. ¹⁰⁷	Yes after MOE ends. ¹⁰⁸
Estate recoveries (2004, latest data) ¹⁰⁹	\$361,766,396	\$0
As a % of nursing home spending Range from 5.8% (Oregon) ¹¹⁰ to 0.0% (Georgia)	U.S. Average: 0.8%	0%

¹⁰⁴ Tax Foundation, "State and Local Tax Burdens: All States, One Year, 1977 – 2010," "Table: 2010 State-Local Tax Burden Compared to U.S. Average," October 23, 2012,

<http://taxfoundation.org/article/state-and-local-tax-burdens-all-states-one-year-1977-2010>

¹⁰⁵ State Health Facts, The Henry J. Kaiser Family Foundation, "State Budget Shortfalls, SFY2013,"

<http://kff.org/other/state-indicator/state-budget-shortfalls-sfy13/?state=NJ>.

¹⁰⁶ "Nearly half of all Americans will outlive their assets, dying with practically no money at all. Even more worrisome, that's true even among households that met the traditional standards for secure retirement income. Economic factors and changes in employer pensions and in economic reality have made it much harder to stretch income and assets so they last, especially as people live longer." Source: Michael Hiltzik, "A crisis for the very old: They're outliving their assets," *Los Angeles Times*, July 16, 2013, <http://www.latimes.com/business/la-fi-hiltzik-20130717,0,2211926.column>.

¹⁰⁷ The Affordable Care Act's "maintenance of effort" requirement currently prevents states from making Medicaid eligibility rules stricter than they were when the Act became law on March 23, 2010. This requirement is due to expire January 1, 2014. Maine, Rhode Island, Wisconsin and Vermont intend to reduce eligibility next year. Source: Phil Galewitz, "Amid Health Law Expansion, Some States Trim Medicaid Rolls," *Kaiser Health News*, August 18, 2013, <http://www.kaiserhealthnews.org/Stories/2013/August/19/medicaid-cuts-in-four-states.aspx>.

¹⁰⁸ Georgia could tighten some Medicaid LTC financial eligibility standards including, for example, community spouse resource allowance and monthly maintenance needs allowances.

¹⁰⁹ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy, "Medicaid Estate Recovery Collections," Policy Brief No. 6, September 2005, p. 8, <http://aspe.hhs.gov/daltcp/Reports/estreccol.pdf>.

¹¹⁰ The estate recovery table gives Arizona's collections as a percent of nursing home spending as 10.4 percent, but footnotes it thus: "Arizona's estate recovery collections, as a percentage of nursing home spending, are not comparable to any other state because comprehensive prepaid managed care contracts dominate the state's Medicaid program, and nursing home care provided under these contracts is not identified separately for reporting purposes."

Home equity for LTC financing Medicaid home equity exemption ¹¹¹	From \$536,000 to \$802,000	\$536,000 as of 2013
Private long-term care insurance		
LTCI market penetration		
Private LTCI policies	6,485,598 ¹¹²	145,914 ¹¹³
Policies per 1000 population	45 ¹¹⁴	35, Rank 37
LTC partnership ¹¹⁵	31 states approved	Yes, not promoted
LTCI tax incentives ¹¹⁶	36 states and DC	Federal deduction carry through only

Georgia's Medicaid long-term care financial eligibility criteria are already tighter than some states, but in the absence of the Affordable Care Act's Maintenance of Effort requirement, due to expire January 1, 2014, the state could tighten them further, as explained in more detail in the section on eligibility previously. Georgia does have an estate recovery program now, although it is unlikely to generate significant revenue as explained in that section. The state Legislature opted for the lower home equity exemption cap mandated by the 2005 Deficit Reduction Act, \$536,000. Private long-term care insurance market penetration is relatively low in Georgia. Although the state has a Long-Term Care Partnership Program, it has not been effectively promoted according to agents interviewed for this study. Georgia lacks state-level tax incentives for the purchase of private long-term care insurance.

A state's long-term care vulnerability is higher if it:

- (1) Has and maintains relatively easy Medicaid long-term care financial eligibility standards
- (2) Recovers relatively less from former recipients' and their spouses' estates
- (3) Has a higher home equity exemption level, and
- (4) Has less and/or does less to encourage private long-term care insurance.

7. How strong is dependency on public programs (entitlement mentality) cradle to grave?

¹¹¹ Medicaid had no cap on home equity until the Deficit Reduction Act of 2005 which required states to limit the home equity exemption to \$500,000 or \$750,000. As of 2013, those limits have increased to \$536,000 to \$802,000.

¹¹² Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 37, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

¹¹³ *Ibid.*, p. 103.

¹¹⁴ *Ibid.*

¹¹⁵ American Association for Long-Term Care Insurance, "What States Have Approved Long-Term Care Partnership Insurance For Sale?" <http://www.aaltci.org/long-term-care-insurance/learning-center/long-term-care-insurance-partnership-plans.php#approved>.

¹¹⁶ David Baer and Ellen O'Brien, AARP Public Policy Institute, "Federal and State Income Tax Incentives for Private Long-Term Care Insurance," #2009-19, November 2010, Table 5: Structure of State Tax Incentives for Long-Term Care (LTC) Insurance, 2007, p. 10, <http://assets.aarp.org/rgcenter/ppi/econ-sec/2009-19-tax-incentives.pdf>.

	<u>United States</u>	<u>Georgia</u>
Births financed by Medicaid (2010) ¹¹⁷	47.8%	41.9%
Range: From 69% in Louisiana to 24% in Hawaii		
Supplemental Nutrition Assistance Program (Food Stamps), 2012 ¹¹⁸		
Participants (avg. per month)	46,609,072	1,912,839
Percent of population ¹¹⁹	14.8%	19.3%
Total annual benefits	\$74,619,344,626	\$3,119,435,907
Avg. benefit per person per month	\$133.41	\$135.90
Welfare exceeds minimum wage ¹²⁰ in 35 states and ranges from \$5.36/hr. in Idaho to \$29.13 in Hawaii		
		\$6.76, Rank: 41
Social Security Disability Insurance (SSDI) replaces work ¹²¹	\$144 billion, trust fund depleted in three years	
SSDI Beneficiaries, Ages 18-64 ¹²²	9,082,367	284,077
Percent of population ¹²³	2.9%	2.9%
Unfunded pension liabilities of state and local governments	\$3 trillion ¹²⁴	
To fully fund would require:	\$1,385 tax increase per household per year for 30 years ¹²⁵	\$803 tax increase per household per year for 30 years ¹²⁶

¹¹⁷ Anne Rossier Markus, JD, PhD, MHS, *et al.*, "Medicaid Covered Births, 2008 Through 2010, in the Context of the Implementation of Health Reform," *Women's Health Issues*, Vol. 23, Issue 5, September 2013, Table: State-Based Medicaid Birth Estimates, [http://www.whijournal.com/article/S1049-3867\(13\)00055-8/fulltext#sec3.1](http://www.whijournal.com/article/S1049-3867(13)00055-8/fulltext#sec3.1).

¹¹⁸ United States Department of Agriculture, Food and Nutrition Service, Program Data, Supplemental Nutrition Assistance Program, Annual State Level Data: FY 2008-2012, <http://www.fns.usda.gov/pd/snapmain.htm>.

¹¹⁹ United States population as of September 10, 2013: 316,646,460. Source: United States Census Bureau, "U.S. and World Population Clock," <http://www.census.gov/popclock/>. For state populations: United States Census Bureau, "State and County Quick Facts," <http://quickfacts.census.gov/qfd/index.html>.

¹²⁰ "If one looks at this as an hourly wage (as shown in Table 3), it is easy to see that welfare pays more than a minimum-wage job in 33 states-in many cases, significantly more. In fact, in a dozen states and the District of Columbia, welfare pays more than \$15 per hour." Source: Michael Tanner and Charles Hughes, "The Work vs. Welfare Trade-Off, 2013: An Analysis of the Total Level of Welfare Benefits by State," Cato Institute, Washington, DC, 2013, Table 3 Hourly Wage Equivalents, pps. 8-9, http://object.cato.org/sites/cato.org/files/pubs/pdf/the_work_versus_welfare_trade-off_2013_wp.pdf.

¹²¹ "The program's expenditures have doubled over the last decade, reaching an estimated \$144 billion this year. Spending has risen so rapidly that SSDI's trust fund is projected to be depleted just three years from now. ... The result is that people capable of working are instead opting for the disability rolls when confronted with employment challenges." Source: Tad DeHaven, "The Rising Cost of Social Security Disability Insurance," Policy Analysis No. 733, Cato Institute, August 6, 2013, p. 1, http://object.cato.org/sites/cato.org/files/pubs/pdf/pa733_web.pdf.

¹²² *State Health Facts*, The Henry J. Kaiser Family Foundation, "Total Disabled Social Security Disability Insurance (SSDI) Beneficiaries, Ages 18-64," <http://kff.org/medicare/state-indicator/total-ssdi-beneficiaries/>

¹²³ United States population as of September 10, 2013: 316,646,460. Source: United States Census Bureau, "U.S. and World Population Clock," <http://www.census.gov/popclock/>. For state populations: United States Census Bureau, "State and County Quick Facts," <http://quickfacts.census.gov/qfd/index.html>.

¹²⁴ Jeffrey A. Miron, "State and Local Pension Liabilities," Cato Institute, July 17, 2013, <http://www.cato.org/blog/state-local-pension-liabilities>.

Nursing facility residents with . . . ¹²⁷		
Medicaid as primary payer,	63%	72%, Rank: 5
Medicare as primary payer,	14%	13%, Rank: 31
Other as primary payer	22%	15%, Rank: 46
Medicaid recipients with prepaid burial plans that avoid spend down requirements	Approx. 80% ¹²⁸	60%

Georgia ranks well on all of the categories of “entitlement mentality” except food stamp use and dependency on Medicaid for long-term care. Medicaid-financed births, welfare payments compared to minimum wage, unfunded pension liabilities, and Medicaid prepaid burials are all below the national average and dependents of Social Security Disability Insurance (SSDI) equal the national average. Georgia’s food stamp utilization is nearly a third higher than the national average and the state ranks fifth highest in the nation on the percentage of nursing facility residents who rely on Medicaid as the primary payer.

A state’s long-term care vulnerability is higher to the extent its pension liabilities are unfunded and if its citizens are relatively more dependent on publicly funded safety net programs.

Assign a weight and score in the Table of Long-Term Care Vulnerability for a state’s unfunded pension liabilities and its citizens’ social welfare dependency.

Conclusion: National and Georgia

From the foregoing analysis, it is hard to reach any other conclusion than to expect the current long-term care service delivery and financing system to face severe, possibly fatal, challenges as the Age Wave crests and crashes on America. Absent extraordinary improvements in the national and state economies generating huge new revenues to support large and growing public programs and pensions, it is difficult to see how those programs’ and pensions’ promises will be met. A sensible conclusion is that long-term care scholarship and public policy should angle away from narrow, marginal reforms of specific service and financing problems toward comprehensive analysis and potentially radical restructuring with much heavier reliance on private planning and individual responsibility.

¹²⁵ “We calculate increases in contributions required to achieve full funding of state and local pension systems in the U.S. over 30 years. Without policy changes, contributions would have to increase by 2.5 times, reaching 14.1% of the total own-revenue generated by state and local governments. This represents a tax increase of \$1,385 per household per year, around half of which goes to pay down legacy liabilities while half funds the cost of new promises.” Source: Robert Novy-Marx and Joshua D. Rauh, The Revenue Demands of Public Employee Pension Promises,” Working Paper 18489, National Bureau of Economic Research, October 2012, <http://www.nber.org/papers/w18489>.

¹²⁶ *Ibid.*, Table 4--Required Increases for Full Funding by State, No Policy Change, p. 48.

¹²⁷ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 106, <http://www.aarp.org/home-garden/livable-communities/info-09-2012/across-the-states-2012-profiles-of-long-term-services-supports-AARP-ppi-ltc.html>.

¹²⁸ Author’s estimate based on interviews with scores of Medicaid long-term care financial eligibility workers, supervisors, and state policy specialists in dozens of states.

Recommendations

1. In light of the oncoming wave of aging baby-boomers, many of whom will become frail and infirm, and recognizing that Medicaid is not a viable long-term care funding source for the long term, Georgia officials, legislators and policy-makers should re-evaluate the current momentum of relying more and more heavily on Medicaid to fund long-term care.
2. Instead of making Medicaid long-term care more desirable by rebalancing to home- and community-based care while leaving financial eligibility as generous as it is, the state should seek ways to target scarce public resources to the neediest Georgians and to eliminate access to publicly funded benefits by middle-class and affluent people without their prepaying for care or repaying from their estates.
3. To avoid “crowding out” alternative private sources of long-term care financing and in order to encourage a privately financed home and community-based services infrastructure, Georgia should tighten Medicaid long-term care eligibility criteria as much as possible under federal law as soon as the maintenance of effort restriction in the Affordable Care Act expires.
4. Especially, the state should seek waivers to enable it to eliminate or severely reduce the home equity exemption under Medicaid from its current level of \$536,000 in order to encourage the use of home equity conversion to fund home care, assisted living and nursing home care privately.
5. Georgia should review its lien and estate recovery program under Medicaid, study other states that operate their programs more successfully, and seek laws, regulations and judicial interpretations to maximize non-tax revenues from this source.
6. With the sovereign debt of the United States at \$17 trillion and the combined infinite-horizon unfunded liabilities of Social Security (\$23.1 trillion) and Medicare (\$43 trillion) at \$66.1 trillion, Georgia should begin to wean the state off dependency on federal funds instead of reaching for more and more.
7. Gradually but persistently the state should move away from publicly funded entitlement programs like Medicaid that increase a spreading “entitlement mentality” and sap its citizens’ sense of personal responsibility.

Appendix: Table of Long-Term Care Vulnerability

An Excel worksheet can be found here: <http://tinyurl.com/k4vld92>. The worksheet allows the user to apply weights to each of the seven categories of long-term care vulnerability and to assign scores within each of the sub-categories. First assign weights to each variable reflecting your judgment of its importance. The worksheet will automatically calculate the maximum number of points you may assign within that variable. Assign points for the nation and your state based on data sources provided in this report or based on other data consistent across the country.

For example, the author has completed the following “Table of Long-Term Care Vulnerability” for the United States and Georgia. In time, we hope to have such worksheets available for every state, making it possible to compare states’ long-term care vulnerability according to standard, objective criteria as weighted subjectively by individual users based on their own systemic knowledge, analysis and opinion.

Please consider this worksheet a “beta” version under development.

The following two pages is a Table of Long-Term Care Vulnerability for Georgia as completed by the author.

Table of Long-Term Care Vulnerability

1. How many older people coming?

	Weight (%)	Max Score				
	5	50				
<u>People age 85+</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
Number and percent in 2012			6,426,000 / 2%	10	142,000 (1.4%)	12
2012 to 2032 increase			69%	5	121%	2
2012 to 2050 increase			224%	2	375%	0
			Total Score for Category 1	17		14

2. How sick are they?

	Weight (%)	Max Score				
	5	50				
<u>People age 65+ with disabilities, 2010</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(% and Rank)	
a. Self-care difficulty			8.8%	8	9.7% 9	5
b. Cognitive difficulty			9.5%	7	11.1% 7	4
c. Any disability			37%	4	40.0% 11	3
<u>Residents with dementia, 2010</u>			46%	3	49.0% 17	2
			Total Score for Category 2	22		14

3. How viable is Medicaid as a long-term care payer?

	Weight (%)	Max Score				
	15	150				
<u>Expenditure trends</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(%, Rank)	
Percent of budget for Medicaid			23.70%	6	20.50%	8
Medicaid LTSS spending change for older people and adults with physical disabilities			28%	5	+0%, 46th	8
Medicaid nursing facility spending change			12%	8	-15%, 50th	10
Medicaid HCBS spending change for older people and adults with physical disabilities			70%	6	109%, 10th	2
Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities			9%	5	13%, 7th	2
Federal Medical Assistance Percentage (FMAP)			50% (minimum)	8	65.56%	10
<u>Other Medicaid sub-factors</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(%, Rank)	
Medicaid expansion under ACA?			26 yes; 22 no; 3 undecided	3	No a/o 9/10/13	6
Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy)			Easy	4	Easy	4
Low reimbursement vulnerability (shortfall per SNF bed day)			\$22.34	3	\$12.48	4
Cost shifting: Medicaid nursing home rate as percentage of private pay rate			92.20%	4	89.40%	4
<u>Dual eligibles vulnerability</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(%, Rank)	
Dual eligibles as share of all Medicaid enrollees			15%	3	16%	2
Duals as share of all aged and disabled enrollees			60%	3	62%	2
Dual Eligible Spending as % of Total Medicaid			39%	3	32%	4
<u>Rebalancing vulnerability</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
			(Number, Rank)		(%, Rank)	
Family Caregivers #/1000, Rank			137, 25	8	139, 23	9
Value in \$Million/1000, Rank			\$1,460, 25	8	\$1,330, 40	5
Ratio, Rank			3.8, 25	8	6.6, 5	10
<u>Managed care vulnerability</u>			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(%, Rank)	
Managed care for aged, blind and disabled recipients?			Expanding	6	No	12
Managed care for "dual eligibles"?			Expanding	6	No	12
			Total Score for Category 3	97		114

4. How reliable is federal revenue on which Medicaid mostly depends?

	Weight (%)	Max Score				
	20	200				
			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
					(#, Rank)	
Total Medicaid spending (2009)			US: \$368,330M	15	\$7,461M 14	10
Five year % increase (2004-2009)			29%	15	-16%, 51	20
Federal and state shares of Medicaid			63.7% federal; 36.3% state	15	29.40%	17
Dependency on "provider taxes"			Every state but Alaska	10	3 taxes, 1+ over 3.5%	2
Social Security role in sustaining Medicaid (2013 infinite-horizon unfunded liability)			\$23.1 trillion	12	Vulnerable	8
Medicare role in sustaining Medicaid (2013 infinite-horizon unfunded liability)			\$43.0 trillion	12	Vulnerable	8
Federal debt			\$16.7 trillion (a/o 09/22/13)	10	Highly Vulnerable	6
			Total Score for Category 4	89		71

5. How reliable is state revenue on which Medicaid secondarily depends?
State economies must generate sufficient revenue to support LTC financing.

	Weight (%)	Max Score				
	20	200				
			<u>United States</u>	<u>Score</u>	<u>State</u>	<u>Score</u>
<u>Rich States, Poor States "Economic Competitiveness Index"</u>						
Economic Performance Rank			From WY #1 to MI #50	25	33	15
Economic Outlook Rank			From UT #1 to NY#50	25	10	27
Forbes Best States for Business and Careers			From Utah #1 to Maine #50	25	8	30

"Fiscal Policy Report Card," Grades state Governors from A to F on their fiscal policies		From Sam Brownback (R), Kansas, 69, A To Pat Quinn (D), Illinois, 16, F	25	Nathan Deal (R), score 53, grade C	15
Mercatus "Freedom Index"					
Combined personal/economic rank; change from 2009		From #1, North Dakota; +4 To #50, New York; 0% change	25	#9, +11	30
Tax Foundation State-Local Tax Burden		U.S. Average: 9.9%; Range: #1, New York, 12.8% to #50, Alaska, 7.0%	25	#33, 9.0%	15
State Budget Shortfalls (2013)		30+DC Yes	10	Yes, \$300M	7
		Total Score for Category 5	160		139
6. How much private pay is available to relieve LTC financing pressure on Medicaid?					
	Weight (%)	Max Score			
	15	150			
	United States	Score		State	Score
Asset spend down potential	Higher if easy eligibility can become less easy	10		Yes, after MOE ends.	10
Estate recoveries (2004, latest data)					
Total	Total: \$361,766,396			\$0	
As a % of nursing home spending	U.S. Average: .8%			0%	
Range	From 5.8% (Oregon) to 0.0% (Georgia)	12			0
Home equity for LTC financing					
Medicaid home equity exemption	From \$536,000 to \$802,000 as of 2013	10		\$536,000	10
Private long-term care insurance					
LTCI market penetration	6,485,598	10		145,914	5
Private LTCI policies	45	10		35, Rank 37	5
Policies per 1000 population	31 states approved	10		Yes, not promoted	7
LTC partnership	36 states and DC	15		Federal deduction, carry through only	10
LTCI tax incentives	Total Score for Category 6	77			47
7. How strong is dependency on public programs (entitlement mentality) cradle to grave?					
	Weight (%)	Max Score			
	20	200			
	United States	Score		State	Score
Births financed by Medicaid (2010)	U.S.: 47.8%				
Range:	From 69% in LA to 24% in HI	7		41.90%	8
Supplemental Nutrition Assistance Program (Food Stamps), 2012					
Participants (ave. per month)	46,609,072	5		1,912,839	2
Percent of population	14.80%	4		19.30%	1
Total annual benefits	\$74,619,344,626	5		\$3,119,435,907	4
Ave. benefit per person per month	\$133.41	5		\$135.90	4
Welfare exceeds minimum wage in . . .					
	35 states and ranges from \$5.36/hr. in Idaho to \$29.13 in Hawaii	8		\$6.76, Rank: 41	10
Social Security Disability Insurance replaces work					
	144 billion, trust fund depleted in three years				
SSDI Beneficiaries, Ages 18-64	9,082,367			284,077	
Percent of population	2.90%	7		2.90%	7
Unfunded pension liabilities of state and local governments					
	US: \$3 trillion				
To fund would require:	\$1,385 tax increase per household per year for 30 years	4		\$803 tax increase per household per year for 30 years	7
Nursing facility residents with . . .					
Medicaid as primary payer,	63%	5		72% 5	1
Medicare as primary payer,	14%	5		13% 31	3
Other as primary payer	22%	5		15% 46	1
Medicaid recipients with prepaid burial plans that avoid spend down requirements					
	Approx. 80%	7		65%	8
	Total Score for Category 7	67			56
Totals					
	Weight (%)	Max Score	Score (out of 1,000)		Score (out of 1,000)
	100%	1000	529		455

List of Interviewees

Adrienne Askew, Medicaid Eligibility Specialist, Floyd County Division of Family and Children Services, Rome, Ga.

Pam Atkins, Medicaid Eligibility Specialist, Floyd County Division of Family and Children Services, Rome, Ga.

Peter Bell, President, National Reverse Mortgage Lenders Association, Washington, DC

Rep. Jeff Brown [Retired], Georgia House of Representatives, LaGrange, Ga.

Denise Carpenter, ABD Supervisor, Region 1, Division of Family and Children Services, Ft. Oglethorpe, Ga.

Tom Carswell, Assistant Director, Division of Insurance Product Review, Office of the Insurance and Fire Safety Commissioner, Atlanta

Jennifer Chumley, Medicaid Eligibility Specialist, Floyd County Division of Family and Children Services, ABD Unit, Rome, Ga.

Walter Coffey, President & C.E.O., LeadingAge Georgia, Atlanta

Vivian Cook, ABD Supervisor, DeKalb County, Decatur, Ga.

Representative Sharon Cooper, District 43, Majority Caucus Chairman-Emeritus, House Health & Human Services Committee-Chairman, Georgia House of Representatives, Marietta, Ga.

Richard E. Dunn, Director, Health and Human Services Division, Governor's Office of Planning and Budget, Atlanta

Justin K. Durrance, Chief Deputy Commissioner of Insurance, Office of Insurance and Safety
Fire Commissioner Ralph T. Hudgens, Atlanta

Sister Edge, Legislative Assistant, Thompson Victory Group, Atlanta

Jason Fernandes, Director, Georgia State Senate Budget and Evaluation Office, Atlanta

Blake T. Fulenwider, Health Reform Administrator, Governor's Office of Planning and Budget, Atlanta

Senator Tim Golden, Chairman, Insurance & Labor Committee, Georgia State Senate, Valdosta, Ga.

Richard Green, President, Senior Securities LTC, Woodstock, Ga.

Greg Heath, Administrator, A.G. Rhodes Health & Rehab, A.G. Rhodes of Wesley Woods, Atlanta, Ga.

Tom Hebrank, President, Advanced Planning Solutions, Marietta, Ga.

Senator Jack Hill, District 4, Chairman, Appropriations Committee, Reidsville, Ga.
Jon Howell, President and CEO, Georgia Health Care Association, Stockbridge, Ga.

Ralph Hudgens, Insurance and Fire Safety Commissioner, Atlanta

Catherine Ivy, Executive Director, NASW Georgia Chapter, Atlanta

Cynthia Knight, Acting ABD Supervisor, Floyd County Division of Family and Children Services, Medicaid Eligibility Specialist, Rome, Ga.

Mary Knowles, ABD Supervisor, Region 1, Division of Family and Children Services, Summerville, Ga.

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Ryan Mahoney, Vice President, Georgia Chamber Center for Competitiveness, Georgia Chamber of Commerce, Atlanta

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Steve Manders, Director, Insurance Product Review, Office of Commissioner of Insurance Ralph Hudgens, Atlanta

Margie M. Coggins Miller, Senior Budget and Policy Analyst, House Budget and Research Office, Atlanta

Stefanie R. Papps, Policy Analyst, Health and Human Services Division, Governor's Office of Planning and Budget, Atlanta

Larry J. "Butch" Parrish, Representative, Georgia House of Representatives, Chairman of the Health Subcommittee of House Appropriations, District 158, Swainsboro, Ga.

Jerry Patton, L.N.H.A., CHC, Chief Operating Officer, A.G. Rhodes, Atlanta,

Derwin Philpot, FICM, DeKalb County, Decatur, Ga.

Cleveland F. Robinson, Administrator, DeKalb County, Decatur, Ga.

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Mary Stanley, Administrator and Acting Field Program Specialist, Region 3, Division of Family and Children Services, Bartow County, Ga.

O. Graham Thompson, Principal, Thompson Victory Group, Atlanta

Senator Renee S. Unterman, Chairman, Health & Human Services Committee, Georgia State Senate, Buford, Ga.

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