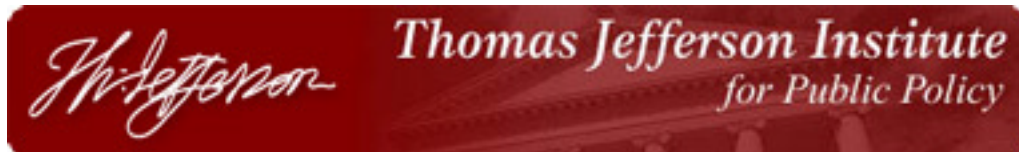
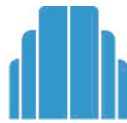


The Index of Long-Term Care Vulnerability: A Case Study in Virginia

presented by the



Researched and written by:



CENTER FOR
LONG-TERM CARE
REFORM



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

November 2013

Thomas Jefferson Institute for Public Policy

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Foreword

Virginia is faced with a serious problem as are all states: the aging population requires us all to figure out how to handle the “costs” that this is going to bring to government and personal budgets.

Long Term Care is one of the more important problems facing all families as parents, brothers and sisters and aunts and uncles live longer and longer.

What are the costs today, what the projections for these costs in the future, and how should we consider restructuring this need for Long Term Care in order for those who need it receive it, and that the burden on government – on the taxpayers – is kept within reasonable bounds?

It is these questions and concerns that prompted the Thomas Jefferson Institute to ask Stephen Moses of the Center for Long Term Care Reform to look into our program and, with his expertise from doing similar work in other states, to suggest what we ought to do here to prepare for this growing need within our society.

Four concerns popped out to me in this study that need to be opening and frankly discussed. They are:

- 1) Long-term care is expensive, funded mostly by Medicaid (considered part of our nation’s welfare program), heavily dependent on already strained state and federal revenue, and facing an on-coming wave of aging boomers who will test the adequacy of scarce public resources.
- 2) Virginia is one of only seven states in which the age 85 plus population, the cohort most likely to need LTC, is projected to more than quadruple between 2012 and 2050, up 307%! So financing long-term care in Virginia will become a huge problem.
- 3) The Commonwealth has doubled down on its Medicaid-financed LTC system by implementing major new programs to (a) “rebalance” services from nursing home care to home care (making Medicaid more desirable) and (b) to “manage” care by turning it over to large managed care organizations (making Medicaid recipients more vulnerable to cost cutting and quality problems).
- 4) While ramping up Medicaid for long-term care, Virginia has not done enough to encourage private sources of LTC financing that could relieve financial pressure on the tax-financed program. Asset spend down, estate recovery, home equity conversion and private long-term care insurance could and should contribute far more to financing quality LTC services.

This study, “The Index of Long-Term Care Vulnerability: A Case Study in Virginia,” focuses on this problem and offers some policy alternatives. At the end (in the Appendix) there is worksheet/an index process that policy makers, policy influencers and others can use to determine long term care needs depending on the variables outlined in this report. This is a serious problem that needs to be confronted sooner than later.

Michael W. Thompson, President
Thomas Jefferson Institute for Public
Policy November 2013

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

Preface

The [Thomas Jefferson Institute for Public Policy](http://www.thomasjeffersoninst.org) (TJI)¹ is a 501(c)(3) non-profit, nonpartisan research institute whose mission is “to provide Virginia's political, business, academic, community and media leadership with thoughtful, realistic, useful and non-partisan analysis of public policy issues confronting our Commonwealth.” TJI contracted with the [Center for Long-Term Care Reform](http://www.centerltc.com) (CLTCR)²--an independent, non-partisan research institute--to conduct a study of Medicaid and long-term care financing in Virginia. Field work on this project began June 3, 2013 and concluded June 27, 2013. This report is the result of this work.

CLTCR president Stephen Moses interviewed 27 people with knowledge and expertise related to long-term care financing in Virginia including key public officials and representatives of interest groups with stakes in long-term care service delivery and financing. All of those interviewed are enumerated at the end of this report in the “List of Interviewees.” Each study participant received an electronic copy of this report. A copy of this report is available on the Thomas Jefferson Institute’s website here: <http://www.thomasjeffersoninst.org>, by request to info@centerltc.com or by downloading it from the CLTCR’s website here: <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 Virginia’s eligibility system, (2) review of Virginia’s state-specific Medicaid eligibility rules online and through interviews with Department of Medical Assistance Services (DMAS) staff and Department of Social Services (DSS) eligibility staff in three counties, (3) analysis of Medicaid planning techniques used in Virginia, (4) study of long-term care providers’ perspectives and (5) examination of private LTC financing alternatives such as estate recovery, home equity conversion and long-term care insurance.

Acknowledgements

We want to thank everyone who agreed to be interviewed for this study. Special appreciation is due staff of the Virginia Department of Medical Assistance Services and Department of Social Services who took time away from their heavy workloads to be interviewed for this study. Michael W. Thompson, Chairman and President of the Thomas Jefferson Institute for Public Policy and his colleague Charlie Judd rendered assistance by recommending interviewees and facilitating appointments. Their support and that of their organization were important to the successful completion of this project.

¹ The Thomas Jefferson Institute for Public Policy’s website is www.thomasjeffersoninst.org.

² The Center for Long-Term Care Reform’s website is www.centerltc.com.

Executive Summary

Long-term care (LTC) for the elderly is already a large risk and expense for private citizens and public programs. The need for and cost of LTC 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 Virginia's. Yet major initiatives at the federal level and in Virginia are underway to expand Medicaid coverage in general and to make the program's LTC benefits more attractive, accessible and efficient. Virginia Medicaid aspires to achieve those goals by rebalancing care from mostly institutional services to mostly home and community-based services and by turning over management of long-term care for more recipients with higher acuity care needs to managed care organizations.

Virginia faces multi-faceted long-term care problems including (1) a rapidly increasing elderly population with (2) much higher numbers of disabled or dementia-afflicted people coming soon and (3) Medicaid already strained as the principal LTC payer dependent on (4) funding from the heavily indebted federal government as supplemented by (5) state revenues constrained by current recessionary and other budgeting pressures and promising, but limited future economic prospects with (6) very little private financing of LTC to relieve the budgetary pressure on public programs in the context of (7) heavy public dependency on social programs already and (8) a growing "entitlement mentality" among the citizenry.

By focusing on improving the state's current long-term care service delivery and financing program without fully taking into account this full range of problems and addressing it, Virginia runs the risk of modifying a broken LTC system that cannot survive the larger on-coming 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 Virginia reassess its current LTC initiatives and move in the direction of reducing dependency on public programs while attracting much more private revenue into the LTC financing mix.

National Overview

The risk of needing some form of long-term care after age 65 is 69%.³ The catastrophic risk of needing five years or more is 20%.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.

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.*

Long-term care (LTC) is custodial or medical assistance needed for three months or more due to an inability to independently perform activities of daily living. LTC is expensive whether received in a nursing home, an assisted living facility or in one's own home.⁵

Most people, when asked, say they believe Medicare pays for long-term care. It does not. But, its sister program Medicaid does pay for most expensive long-term care.⁶ Contrary to conventional wisdom, Medicaid long-term care benefits are relatively easy to qualify for financially.⁷ Peer reviewed research indicates that the availability of Medicaid long-term care benefits crowds out private financing and planning.⁸ Other reliable research shows that, ironically, the rich gain as much or more from Medicaid's long-term care benefit as do the poor.⁹

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,

⁵ "[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.

⁶ 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>.

⁷ Income rarely interferes with Medicaid LTC 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>.

⁸ 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.

⁹ "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.

but the common belief that home care saves Medicaid money is dubious.¹⁰ States also try to save money by expanding managed care to new populations, including the aged, blind and disabled, and even high-risk, high-cost “dual eligibles,” who qualify for both Medicaid and Medicare. But managed care creates serious access and quality challenges, especially for these very vulnerable groups, as advocates for seniors and the disabled often warn.¹¹

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 immediately and Medicaid, before long. Widespread Medicaid reform measures, such as rebalancing (moving from mostly institutional services to mostly home and community based services), may or may not save money, but they will make Medicaid LTC financing more popular and sought after. Managed care for high-risk populations may result in unavoidable problems and unanticipated costs.

Long-Term Care in Virginia

Like every state in the nation, Virginia faces an onslaught of frail and infirm elders as the demographic wave of aging baby boomers advances. But Virginia’s risk is greater than most. The commonwealth’s 142,000 citizens over age 85 now will more than quadruple by 2050 at a rate (307%), seventh highest in the nation.¹² Long-term care costs in Virginia approach national averages, higher for some services, lower for others: \$226 per day for a semi-private nursing home room compared to \$248 nationally. A private, one-bedroom apartment in assisted living costs \$3,815 per month on average in Virginia versus \$3,550 nationally. Home health aides average \$19 per hour and adult day services \$60 per day in Virginia, versus \$21 and \$70, respectively across the country.¹³ Virginia’s population age 65-plus with disabilities is slightly lower and its proportion of nursing facility residents with dementia is slightly less compared to the rest of the country.¹⁴ Virginians with private long-term care insurance are 6.5% of the population age 40 and

¹⁰ 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.

¹¹ See, for example, 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.centerltc.com/BriefingPapers/5.htm.

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. 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>.

¹³ 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>.

¹⁴ Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, pps. 323, 326, <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>.

over, which is well above the 4.5% national average.¹⁵ Public officials in Virginia focused early and intensely on the challenge of future long-term care needs, studying the problem, publishing consumer guides and actively participating in the federal government's "Own Your Future" campaign.¹⁶

As in all states, Medicaid is the dominant payer for long-term care in Virginia. Medicaid consumes 16.9% of the commonwealth's general fund expenditures, exceeding elementary and secondary education (15.8%) and higher education (15.3%), the two next higher budget categories.¹⁷ The program covers the medical needs of a wide swath of Virginians, but not proportionately:

Children, parents/caregivers of children and pregnant women make up 68 percent of the Medicaid beneficiaries, and account for 31 percent of Medicaid spending. Seniors and individuals with disabilities account for the majority of Medicaid spending due to their intensive needs and use of more costly acute and long-term care services.¹⁸

In fact, the 7% of recipients who receive long-term care services account for 35% of Virginia's Medicaid expenditures. Adding non-LTC services for the same group of mostly aged, blind and disabled recipients results in 32% of the caseload accounting for 69% of program costs.¹⁹

Although Virginia's increase of Medicaid expenditure is comparable to other states, a 70% increase over the past 10 years "driven primarily by the growing number of individuals with a disability," the commonwealth "ranks near the lowest levels nationally regarding Medicaid spending per capita (48th in 2009)." Likewise, "Virginia's eligibility criteria are among the strictest in the nation."²⁰ Furthermore, economic prospects are looking up: "Virginia will have modest amounts of additional resources to direct toward high priority spending," according to Governor McDonnell.²¹ All those facts bode

¹⁵ *Ibid.*, p. 323.

¹⁶ See for example: "Long-Term Care: A Consumer's Guide" (http://www.vhi.org/pdf/LTC_text.pdf), "Resources: A To Z" (http://www.vhi.org/pdf/LTC_resources.pdf), "Dementia State Plan: Virginia's Response to the Needs of Individuals with Dementia and their Caregivers" ([http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2272011/\\$file/RD227.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD2272011/$file/RD227.pdf)), and "Own Your Future, Virginia" (<http://vda.virginia.gov/oyf/>).

¹⁷ *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/>.

¹⁸ "The Virginia Medicaid Program at a Glance," Department of Medical Assistance Services, January 2013, http://www.dmas.virginia.gov/Content_atchs/atchs/va-medprg.pdf.

¹⁹ "Medicaid Snapshot and Financing," presentation by Cindi B. Jones, MS, Director, Virginia Department of Medical Assistance Services and Virginia Health Reform Initiative, June 12, 2013, slide #4, <http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingResources/20130610FinalDocument.pdf>.

²⁰ "The Virginia Medicaid Program at a Glance," Department of Medical Assistance Services, January 2013, http://www.dmas.virginia.gov/Content_atchs/atchs/va-medprg.pdf.

²¹ Governor McDonnell's Proposed Amendments to the 2012-2014 Biennial Budget, A briefing for the Joint Meeting of the Senate Finance Committee, House Appropriations Committee, and the House Finance Committee, December 17, 2012, Daniel S. Timberlake, Director, Virginia Department of Planning and Budget, slide #7, <http://dpb.virginia.gov/budget/buddoc13/pdf/BudgetDirectorsPresentation12-17-12.pdf>.

relatively well for Virginia's ability to cope with likely rapid increases in Medicaid, especially LTC, costs.

Who Qualifies for Medicaid Long-Term Care in Virginia?

Medicaid is a means-tested public assistance program often referred to as “welfare.” Yet that term is misleading. Federal law requires very generous income and asset eligibility rules in most states. For example, income rarely interferes with eligibility for Medicaid LTC benefits because most states deduct private medical and LTC expenses from applicants' incomes before asking if they are poor enough to qualify. Very generous exempt assets also apply in all states, such as at least \$536,000 in uncounted home equity, and, in unlimited amounts, a business, one automobile, prepaid burials, term life insurance, Individual Retirement Accounts, home furnishings, and personal belongings.²² These generous eligibility rules are the reason why Medicaid is the dominant payer for long-term care throughout the United States--not only for the poor, but for middle- and upper-middle-class people as well.

Virginia, however, is at least somewhat, an exception to this general rule. The commonwealth is one of only eleven 209-B states. That means it was allowed to retain stricter eligibility rules than were permitted under the new federal Supplemental Security Income Program (SSI) implemented in 1974. Thus, Virginia is not required to and in fact does not honor the “intent to return” rule which requires all non-209-B states to exempt a single Medicaid applicant's home when he or she expresses a subjective intent to return to the home. Unmarried Virginians who want Medicaid to pay for their long-term care must list their homes for sale within six months and use the proceeds of such sales to spend down privately. Likewise, Virginia exempts only \$5,000 of contiguous property value, which is not separately limited in non-209-B states. According to interviewees at the Virginia Poverty Law Center, this policy on contiguous property especially, but several other eligibility policies that are more restrictive in Virginia than elsewhere, cause serious problems for their low-income clients who become entangled in them.²³

Despite its relatively stringent LTC financial eligibility rules, Virginians have a strong incentive to qualify for Medicaid. Medical benefits under the program are very generous and cover most federally approved optional services. A Medicaid official stated in our interview: “One of my staff says if she could drop her state package and get Medicaid she would.” Nor is eligibility radically more difficult to achieve than in non-209-B states. Virginia uses a medically needy income eligibility system, which means it deducts private medical and long-term care expenses from Medicaid applicants' incomes before determining whether their incomes are low enough to qualify. The result is that people with incomes that are substantial, but less than the cost of private nursing home care, which averages over \$5,000 per month, may qualify. Uncounted retainable assets

²² For details, see Stephen A. Moses, “Briefing Paper #2: Medicaid Long-Term Care Eligibility,” Center for Long-Term Care Reform, Seattle, Washington, <http://www.centerlrc.com/BriefingPapers/2.htm>.

²³ Interview with Jill A. Hanken, Esq., Staff Attorney and Kathy Pryor, Elder Law Attorney, Virginia Poverty Law Center, Inc., July 29, 2013.

also abound. According to the Elder & Disability Law Center, a small elder law firm serving Virginia, D.C, and Maryland:

Examples of exempt resources include one vehicle, personal property and household furnishings, burial spaces, pre-paid funerals, life estates in real property, trade or business property essential to self-support, and assets that cannot be converted to cash. For married couples, the family residence is exempt if the healthy spouse is still living there.²⁴

On top of these basic financial eligibility rules, Virginia Medicaid has to cope with sophisticated legal techniques used by elder law specialists to artificially impoverish their relatively prosperous clients in order to qualify for Medicaid. These include the use of promissory notes, Medicaid-compliant annuities, life estates and savings bonds used to shelter or divest often hundreds of thousands of dollars. An internet search for “Medicaid planning in Virginia” will reveal many advertisements for such services similar to this example:

When Medicaid is necessary, we file the Medicaid application, along with all substantiations and explanations. We save clients the hassle of endless hours at the Virginia Department of Social Services to obtain Virginia Medicaid eligibility. Because each long-term care problem is unique, each elder law solution is unique. However, the recommended solutions are carefully planned out so that the majority of the assets a potential Medicaid recipient has saved his or her entire life to leave his or her beneficiaries can be protected from privately paying for nursing home or in-home care.²⁵

“Medicaid is a program that pays for pretty much anyone who needs care and knows how to get it, not just for the poor.” (Virginia Medicaid eligibility worker)

While Medicaid LTC eligibility policy is set and enforced by the Department of Medical Assistance Services, Virginia’s Department of Social Services actually applies the policy. It receives, evaluates and acts upon applications in county offices throughout the commonwealth. For this project, we interviewed Medicaid LTC financial eligibility workers and supervisors in three counties: Fairfax, Chesterfield and Powhatan. As expected, Medicaid planning occurs more frequently and in larger amounts in the more urban Fairfax County. A worker there said, “Medicaid is a program that pays for pretty much anyone who needs care and knows how to get it, not just for the poor.”²⁶

Virginia’s eligibility policy specialist observed, for example, that annuities are a big problem allowing clients of Medicaid planners to divert “hundreds of thousands of

²⁴ “Medicaid Myths,” Elder & Disability Law Center, <http://www.edlc.com/Medicaid-Myths.shtml>, cited September 19, 2013.

²⁵ “Virginia Medicaid Planning,” Timothy K. Palmer, P.C., Elder Law Solutions, <http://www.palmerelderlaw.com/medi.html>, cited September 19, 2013.

²⁶ Interview with eligibility workers in Fairfax County on July 29, 2013.

dollars,” \$900,000 in one case, into Medicaid-compliant annuities.²⁷ Although Virginia has notified federal officials at the Centers for Medicare and Medicaid Services (CMS) of the problem, no corrective action has been taken. “I have no idea why not,” said the eligibility specialist. County workers in Fairfax confirmed that annuities, especially in a spouse’s name, are used to divert otherwise countable assets of an institutionalized spouse away from spend down liability. Likewise a Powhattan worker said: “I cannot believe all these annuities. They have hundreds of thousands of dollars. It used to bother me so much. I’ve learned there are some things I can do nothing about. It’s very rare that I get an application in with big resources without them having seen an attorney.”²⁸

Several reasons explain why Medicaid in Virginia continues to be available to people with substantial wealth. A Fairfax worker said: “We spend an awful lot of time on attorney cases. I had one five inches thick. Verifications are 300 pages. It takes a long time to get through them. Hours for attorney cases. The checklist could take you at least half a day.” Staff cutbacks, burgeoning caseloads and the incredible complexity of Medicaid eligibility rules contribute to workers’ frustration and inability to conduct full reviews and verifications. The “maintenance of effort” (MOE) requirement in the Affordable Care Act prevents Virginia from closing even the few loopholes over which it has control. Staff proposed limits on the use of life estates to qualify and “several regulatory packages to change LTC to tighten up some loopholes” but had to pull the proposals back because of the MOE.²⁹ This is the “Bane of my existence,” said a policy specialist. Although the MOE restriction is due to expire on adult cases January 1, 2014, there is little support at CMS for efforts to target Medicaid LTC cases to the most needy applicants. Absent action by CMS to tighten eligibility policy nationally, Virginia Medicaid would need to see loophole-closing legislation introduced and the state legislature would need to act. This makes corrective action unlikely any time soon.

Rebalancing and Managed Care

Virginia Medicaid has whole-heartedly adopted rebalancing and managed care, two major nationwide initiatives actively promoted by CMS to improve publicly financed long-term care. Rebalancing from institutional to home and community-based services (HCBS) seeks to provide care in the most appropriate, least institutional settings preferred by recipients and to save money. Managed care endeavors to coordinate care delivery more efficiently, to integrate formerly disparate revenue sources such as Medicare and Medicaid, and to save money.

Virginia Medicaid has rebalanced aggressively using six waivers, which allow more control of utilization than would be the case covering personal care under the state plan. Already, the commonwealth has rebalanced 50% of Medicaid for the aged, blind and

²⁷ Interview with Cindy Olson, Eligibility Section Manager, Division of Policy and Research, Department of Medical Assistance Services, Commonwealth of Virginia on June 2, 2013.

²⁸ Interview with Powhattan County eligibility workers on June 26, 2013.

²⁹ Interview with Cindy Olson, Eligibility Section Manager, Division of Policy and Research, Department of Medical Assistance Services, Commonwealth of Virginia on June 2, 2013.

disabled to long-term services and supports in the community.³⁰ In the five year period between 2004 and 2009, Virginia was one of only four states to increase HCBS spending by more than 150 percent.³¹ In the same period, however spending for care in nursing facilities also increased much faster than the average national rate (17% compared to 12%).³² Clearly total LTC expenditures, combining nursing facility and HCBS, continue to increase rapidly. Although rebalancing does not appear to be saving money, it does make Medicaid-financed services more attractive inasmuch as most people prefer to avoid nursing home institutionalization and to receive needed care in their own homes. As more and more Virginians reach the age at which long-term care often becomes necessary, they have fewer reasons now than before to plan to pay for their own care since the way Medicaid is established, it is attractive to many.

Likewise, “managed care” already predominates in Virginia’s Medicaid program: “The majority of Medicaid recipients are covered through contracts with managed care organizations (MCOs) who receive a monthly rate for each enrollee, and are responsible for paying providers directly for the medical services incurred by those individuals.”³³ What is new is that: “In the third phase of reform, the Department of Medical Assistance Services shall seek reforms to include all remaining Medicaid populations and services including long-term care and home- and community-based waiver services into cost-effective, managed and coordinated delivery systems.”³⁴ Virginia Medicaid intends for this managed care initiative to include “dual eligibles,” the fragile, chronically ill and highly expensive Medicaid recipients who also qualify for Medicare. While managing preventive and acute care of low-income women and children has generated substantial savings to Medicaid, there is serious concern among senior advocates that similar savings for frail and chronically ill elderly people may not be achievable without negatively impacting the access to and quality of care.³⁵

LTC Providers’ Perspective

When asked what the biggest challenge facing their profession is, nursing home representatives in most states say “low reimbursement.” Although they provided evidence that Medicaid nursing facility reimbursement in Virginia fell short of allowable

³⁰ Interview with Karen Kimsey, Deputy Director, Complex Care Services, Department of Medical Assistance Services, Commonwealth of Virginia on June 25, 2013.

³¹ 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>.

³² *Ibid*, p. 327.

³³ “Medicaid Reform: HHR-DMAS Project Matrix - Public Document 052113,” p. 3,

<http://www.hhr.virginia.gov/initiatives/healthreform/docs/MedicaidReformMatrixforPublicComment.pdf>.

³⁴ *Ibid*., p. 9.

³⁵ 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.centerltc.com/BriefingPapers/5.htm.

costs by \$10.98 per bed day (6.7%), representatives of the Virginia Health Care Association explained their biggest concerns are making the transition to managed care and heavy regulation.³⁶ They're concerned that Virginia's plan to merge Medicare and Medicaid funding sources and turn over service delivery to big managed care organizations may be unworkable. "We lose money on every Medicaid patient and make money on Medicare patients," they explained. Once those funding sources are merged and spending is controlled by a larger corporate entity, how will nursing home providers fare? How will residents' care quality and access be protected? Those are their biggest worries, especially as pressures grow at the federal level to reduce Medicare nursing home reimbursements and private-payer census has dwindled to a small number of people in the "Medicaid spend-down queue."

On the home care side, the single biggest concern is low reimbursement from Medicaid although following close is segmentation of the market into services for (1) private payers who command top-quality care from private duty nurses or Certified Nursing Assistants and (2) Medicaid dependents who have difficulty qualifying financially and who receive care from aides with lesser training and certification.³⁷ Personal care under Medicaid is a particular concern. At a reimbursement rate of only \$12.91 per hour (compared to \$16 to \$18 for private payers), "we have the indigent taking care of the indigent."³⁸ Personal care providers cater to private payers offering "red-carpet" treatment not only because they pay more, but also because they don't seek to recapture funds spent as Medicaid does.

Second, in severity of concern are "Draconian regulations" that hold personal care homes to a "complete and total" compliance standard without the "substantial compliance" alternative available to other LTC providers. Third, health insurance requirements of the Affordable Care Act may overwhelm personal care providers forcing them to cut hours worked by care staff who are barely getting by now. "This is a low-margin, high-risk business where anytime Medicaid can take back hundreds of thousands of dollars leaving providers of a critical service hanging on by a thread."³⁹ At such low Medicaid reimbursement levels, senior advocates worry that enough caregivers may not be available, especially in more rural areas.⁴⁰ Finally, some of Virginia's Medicaid waivers for home and community based services HCBS have "huge waiting lists because of too few slots."⁴¹ Waiver rules require that total expenditures for HCBS remain below what

³⁶ Interviews with Stephen C. Morrisette, President and Hobart M. Harvey, Vice President Financial Services of the Virginia Health Care Association (VHCA) on June 13, 2013 and with Dana Parsons, Legislative Affairs Legal Counsel Virginia Association of Nonprofit Homes for the Aging (VANHA) on June 27, 2013.

³⁷ Interview with Marcia Tetterton, MS, CAE Executive Director, Virginia Association for Home Care & Hospice on June 27, 2013.

³⁸ Interview with Olivia Jones, President, Virginia Association Personal Care Providers on August 29, 2013.

³⁹ *Ibid.*

⁴⁰ Interview with Jill A. Hanken, Esq., Staff Attorney and Kathy Pryor, Elder Law Attorney, Virginia Poverty Law Center, Inc., July 29, 2013.

⁴¹ *Ibid.*

Medicaid would have had to pay to provide institutional care which forces a strict limit on the number of waiver participants.

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 are used very prominently in Virginia, but should be.

1. **Asset spend down:** As explained above 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. Although, compared to most other states, Virginia's 209-B status allows stricter eligibility rules, the net result is very nearly the same. The home equity exemption of \$536,000 in Virginia (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 LTC 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 LTC 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. The federal government has not published state-level data on estate recoveries since 2005 (based on 2004 data), at which time Virginia recovered only \$776,866 or 0.1% of its 2004 expenditures for nursing home care whereas the national average recovery rate was 0.8% and a leading state's recovery rate was 5.8% (Oregon).⁴² In the past five years, Virginia's estate recoveries have increased from \$560,889 in Fiscal Year (FY) 2008 to \$987,461 in FY 2012, still only a tiny fraction of nursing facility expenditures. The \$892,491 recovered from estates by Virginia in FY 2009 remains only .1% of the \$920 million expended for nursing home care in that year. If Virginia had recovered at the same rate as Oregon (5.8%), the commonwealth would have collected \$52,467,509 more non-tax revenue in that year. Virginia devotes only 1.5 full time equivalent positions (FTEs) to Medicaid estate recoveries, whereas Oregon employs 22 FTEs in its program. Figuring \$50,000 per position for salaries and

⁴² 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>.

double that to include benefits and overhead, Virginia could increase nontax revenues from estate recoveries substantially by adding more staff and working to improve collections. The author recently published a report detailing collections and listing best practices in leading estate recovery states titled “Maximizing NonTax Revenues from MaineCare Estate Recoveries.”⁴³

3. Home equity conversion: The single biggest asset aging people possess is their homes. Over two-thirds of Virginians (68.4%) own their homes which have a median value of \$254,600, far exceeding the national average value of \$186,200.⁴⁴ In the absence of Medicaid’s home equity exemption, \$536,000 in Virginia, 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 begin. Such mortgages become due and payable when the elder mortgagee becomes too ill to remain, moves out, dies or sells. Alternatively, families that 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 an interviewee said in another study in a different state 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.”⁴⁵

4. Private long-term care insurance: Public officials in Virginia recognized the risk and cost of long-term care early and took action to encourage the purchase of private long-term care insurance. The commonwealth participated in the federal government’s “Own Your Future” campaign to educate the public, made available a “Shoppers Guide to Long-Term Care Insurance,” implemented a Long-Term Care Partnership program to encourage the purchase of LTC insurance by forgiving some of the Medicaid asset spend down liability under certain circumstances, and instituted a 15% state income tax credit for the purchase of private LTC insurance. These measures appear to have been somewhat successful as the private LTC insurance market penetration in Virginia is significantly higher

⁴³ Stephen A. Moses, “Maximizing NonTax Revenues from MaineCare Estate Recoveries,” Center for Long-Term Care Reform,” Seattle, Washington and the Maine Heritage Policy Center, Portland, Maine, 2013, <http://www.centerlrc.com/pubs/Maine2013.pdf>.

⁴⁴ United States Census Bureau, “State and County Quick Facts,” <http://quickfacts.census.gov/qfd/states/51000.html>.

⁴⁵ Interview August 19, 2013 with Catherine Ivy, Executive Director, NASW Georgia Chapter, Atlanta, Georgia.

than the national average, 6.5% of the age 40 plus population compared to 4.5% nationally. Nevertheless, a long-term care insurance agent interviewed for this study stated “the market for LTCI is horrible. Everyone is disturbed because insurance companies have increased premiums. These are difficult conversations. Clients who have the insurance are keeping it although they’re not happy about the premium increases. It gives them peace of mind.”⁴⁶ In a large sense, government policy has done a lot to dampen demand for private LTC insurance. By making Medicaid financed care relatively easy to obtain after the insurable event occurs, public policy reduced consumers’ incentive to plan and insure early while premiums are relatively low at younger ages.⁴⁷ Later, after millions of LTC insurance policies had been sold, Federal Reserve Bank quantitative easing, *i.e.*, bond buying, policies forced nationwide interest rates to near zero precluding LTC insurance carriers from making the actuarially required returns on their reserves to be able to pay future claims. The consequence in Virginia and the rest of the country is that more of the burden to finance long-term care falls on Medicaid and less on private LTC insurance carriers.

Outlook

Given the current status and likely development of Virginia’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? Below is a proposed method to answer those questions in any state and an application of the method specifically to Virginia.

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 LTC has many complicated components, such as risk, cost, care giving, service delivery and financing. These 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’re studied in silos rather than comprehensively.⁴⁸

⁴⁶ Telephone interview with Judy L. Redpath, CFP(r), AIF(r), VISTA Wealth Strategies LLC, Reston, Virginia on June 20, 2013.

⁴⁷ 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.

⁴⁸ 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>.

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 “The History of Long-Term Care Financing, or How We Got Into This Mess.”⁴⁹

This Virginia-focused report takes a different approach and asks a different question: Is the current LTC 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 LTC service delivery and financing?

We have developed an Index of Long Term Care Vulnerability that allows policy makers, policy influencers, policy wonks and others interested in this issue to plug in numbers for various pieces of this problem and see what the outcome might be down the road in a few years. This Index is explained in the Appendix and the reader can find two Index Worksheets on page 30: one is completed by the author and one is blank allowing the reader to “play with the variables” and see the outcome. This is explained in the Appendix to this paper.

Conclusion: National and Virginia

From the foregoing analysis and the author’s completed Index, 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/writers and public policy should angle away from narrow, marginal reforms of specific LTC service and financing problems toward comprehensive analysis and potentially radical restructuring with much heavier reliance on private planning and individual responsibility.

Recommendations

1. In light of the on-coming wave of aging baby-boomers, many of whom will become frail and infirm, and recognizing that Medicaid is not a viable LTC funding source for the

⁴⁹ 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.centerlrc.com/BriefingPapers/1.htm>.

long term, Virginia officials, legislators and policy makers should re-evaluate the current momentum to rely more and more heavily on Medicaid to fund long-term care.

2. If Virginia continues to make Medicaid long-term care more desirable by rebalancing to home and community-based care, the commonwealth should seek ways to target scarce public resources to the neediest Virginians and to eliminate access to publicly funded benefits by middle-class and affluent people without them either 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, Virginia should tighten Medicaid LTC eligibility criteria as much as possible under federal law as soon as the maintenance of effort restriction in the Affordable Care Act expires on January 1, 2014.

4. The commonwealth 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. Virginia 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 T) and Medicare (\$43.0 T) being \$66.1 trillion, Virginia should begin to wean the commonwealth off dependency on federal funds instead of reaching for more and more.

7. Gradually but persistently the commonwealth 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: The Index of Long-Term Care Vulnerability

In order to build an effective Index for policy makers and policy influencers, we wanted to confront several questions raised by this report. To reiterate those:

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 “The History of Long-Term Care Financing, or How We Got Into This Mess.”⁵⁰

This report takes a different approach and asks a different question: Is the current LTC 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 LTC service delivery and financing?

To answer those questions, we look closely at the following variables individually and in combination based on comparison of national data and state-level data in a series of state-specific queries:

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 LTC financing pressure on Medicaid?
7. How strong is dependency on public programs (*i.e.*, the entitlement mentality)?

With reasonably 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.⁵¹ 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 LTC service delivery and financing systems. A blank Table of Long-Term Care Vulnerability and one filled out for Virginia applying the author’s own weights and scores are included as embedded objects in the electronic version of this report.

1. How many older people coming?

This is the question of aging demographics. People 85 years of age and older are the most likely cohort to require long-term care. According to AARP, a good “barometer

⁵⁰ 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.centerlrc.com/BriefingPapers/1.htm>.

⁵¹ 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.

for the potential demand for long-term services and supports (LTSS) 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%) between 2012 and 2050. People age 85 or older not only have much higher rates of disability, but they are also much more likely to be widowed and without someone to provide assistance with daily activities.⁵²

<u>People age 85+</u>	<u>United States</u> ⁵³	<u>Virginia</u> ⁵⁴
Number in 2012	6,426,000 (2.0%)	142,000 (1.7%)
2012 to 2032 increase	69%	101%
2012 to 2050 increase	224%	307%

Virginia is one of only seven states in which the age 85 plus population is projected to more than quadruple between 2012 and 2050.⁵⁵

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

When using the blank Index, you need to assign a weight and score in the Table of Long-Term Care Vulnerability.

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 LTC 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>People age 65+ with disabilities, 2010</u>	<u>United States</u> ⁵⁶	<u>Virginia</u> ⁵⁷	<u>Percent Rank</u> ⁵⁸
a. Self-care difficulty	8.8%	8.0%	24
b. Cognitive difficulty	9.5%	8.7%	28
c. Any disability	37%	35%	31
<u>Nursing facility residents with dementia, 2010</u>	46% ⁵⁹	45%	31 ⁶⁰

⁵² 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>.

⁵³ *Ibid.*, p. 36.

⁵⁴ *Ibid.*, p. 322.

⁵⁵ *Ibid.*, p. 7.

⁵⁶ *Ibid.*, p. 37.

⁵⁷ *Ibid.*, p. 323.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*, p. 40.

⁶⁰ *Ibid.*, p. 326.

Virginia’s population age 65-plus with disabilities is slightly lower compared to the rest of the country. The commonwealth’s proportion of nursing facility residents with dementia is slightly less than the national average.

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, less if less. Assign a weight and score for this factor in the Table of Long-Term Care Vulnerability.

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 factors vitally into the question of whether or not the long-term care system now in place can survive. Medicaid’s LTC viability breaks down into several sub-factors.

<u>Expenditure trends</u>	<u>United States</u>	<u>Virginia</u>	<u>Rank</u>
Percent of budget for Medicaid ⁶¹	23.7%	16.9%	
Medicaid LTSS spending change for older people and adults with physical disabilities 2004 to 2009	+28% ⁶²	47%	7th ⁶³
Medicaid nursing facility spending change 2004 to 2009	+12% ⁶⁴	17%	19th ⁶⁵
Medicaid HCBS spending change for older people and adults with physical disabilities 2004 to 2009	+70% ⁶⁶	171%	3rd ⁶⁷
Medicaid HCBS change as a % of LTSS spending for older people and adults with physical disabilities 2004-2009	+9% ⁶⁸	16%	5th ⁶⁹
Federal Medical Assistance Percentage (FMAP)	50% (minimum) ⁷⁰	50% ⁷¹	

⁶¹ *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/>.

⁶² 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. 327; <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>.

⁶³ *Ibid.*

⁶⁴ *Ibid.*

⁶⁵ *Ibid.*

⁶⁶ *Ibid.*

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

Virginia spends a much lower percentage of its budget on Medicaid than the national average. The commonwealth’s long-term care spending for older people and adults with physical disabilities increased rapidly for five years (47%). Nursing facility spending grew far more during the period than the national average (17% vs. 12%). Likewise, Medicaid HCBS spending for the coverage group skyrocketed 171%, 3rd in the nation. Medicaid HCBS as a percentage of LTSS spending increased at nearly double the national rate. Virginia’s Medicaid match equals the federal minimum.

A state’s long-term care vulnerability is higher if its rate on the preceding factors (except FMAP) is higher than the national rate; lower, if lower. 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 HCBS spending is deemed a negative factor because it makes Medicaid a more attractive LTC payer, and discourages private home care financing, private LTC savings or insurance and free care provided by families, friends or charities.⁷²

<u>Other Medicaid sub-factors</u>	<u>United States</u>	<u>Virginia</u>
Medicaid expansion under ACA?	26 yes; 22 no; 3 undecided ⁷³	To be decided
Medicaid LTC eligibility and Medicaid planning (Rank on range from less easy to more easy)	Easy ⁷⁴	Less easy ⁷⁵
Low reimbursement vulnerability (shortfall per SNF bed day)	\$22.34 ⁷⁶	\$10.15 ⁷⁷
Cost shifting: Medicaid nursing home rate as percentage of private pay rate	92.2% ⁷⁸	80.1% ⁷⁹

⁷⁰ *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/>.

⁷¹ *Ibid.*

⁷² For further explanation, see Stephen A. Moses, “Briefing Paper #4: Rebalancing Long-Term Care,” Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerlrc.com/BriefingPapers/4.htm.

⁷³ *State Health Facts*, The Henry J. Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision, as of September 16, 2013,” <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicare-under-the-affordable-care-act/>.

⁷⁴ See footnote #7 for why Medicaid LTC financial eligibility is relatively “easy.”

⁷⁵ Virginia is a 209-B state which allows its Medicaid program to have stricter financial eligibility rules than are allowed under SSI regulations elsewhere in the country.

⁷⁶ “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.

⁷⁷ *Ibid.*, p. 8.

⁷⁸ 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->

On ACA Medicaid expansion, Virginia “is not moving forward at this time.”⁸⁰ The commonwealth’s Medicaid LTC financial eligibility is stricter compared to most states because Virginia is a 209-B state; details above in the section on eligibility. Nursing facilities in Virginia operate at a loss for their Medicaid residents, but that loss is less than half of the national average. The disparity between Virginia’s Medicaid nursing home reimbursement rate and the average private-pay rate is substantially more than the national average, only 80.1% compared to 92.2%.

A state’s long-term care vulnerability is higher if it (1) expands Medicaid under the ACA,⁸¹ (2) if its financial eligibility for Medicaid LTC benefits is more lenient, (3) if its nursing home reimbursement shortfall is higher, or (4) if its Medicaid institutional reimbursement rate is lower compared to its private-pay rate. Federal Medicaid LTC financial eligibility is deemed “easy” because income rarely obstructs eligibility, exempt assets are practically unlimited, and artificial self-improvement through legal Medicaid planning techniques is readily available.⁸²

<u>Dual eligibles vulnerability</u> ⁸³	<u>United States</u>	<u>Virginia</u>
Dual eligibles as share of all Medicaid enrollees	15% ⁸⁴	19% ⁸⁵
Duals as share of all aged and disabled enrollees	60% ⁸⁶	65% ⁸⁷

[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.

⁷⁹ *Ibid.*, p. 325. Based on a Medicaid rate of \$153 and a private-pay rate of \$191.

⁸⁰ Cited as of September 17, 2013. *State Health Facts*, The Henry J. Kaiser Family Foundation, “Status of State Action on the Medicaid Expansion Decision, as of September 16, 2013,” <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>.

⁸¹ Chmura’s December 7, 2012 report titled “The Economic Impact of the Medicaid Expansion on Virginia’s Economy” (<http://www.vrha.org/weekly/articles/1-21-13medicaid.pdf>) concluded: “The economic impact from expanding Medicaid is nearly four times larger with the opting in scenario when compared to opting out of the federal expansion, at least in the 2014 - 2019 timeframe. The uncertainties increase after 2019, and that period was not part of the scope of this study.” Likewise, Drew Gonshorowski of the Heritage Foundation concluded August 21, 2013 in “Medicaid Expansion and State-Level Evaluation in Virginia” (<http://www.insideronline.org/summary.cfm?id=20587>): “[U]sing highly detailed estimates conducted in Virginia, it is clear that the Medicaid expansion begins to drastically cost the state in later years.”

⁸² For details, see footnote #7 and Stephen A. Moses, “Briefing Paper #2: Medicaid Long-Term Care Eligibility,” Center for Long-Term Care Reform, Seattle, Washington, <http://www.centerlrc.com/BriefingPapers/2.htm>.

⁸³ 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

⁸⁴ 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>.

⁸⁵ *Ibid.*

Dual eligibles spending as % of total Medicaid 39%⁸⁸ 40%⁸⁹

Compared to the U.S. as a whole, Virginia has a significantly 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 roughly the same as the national average.

A state’s long-term care vulnerability is higher if it has more high-cost dual eligibles and higher spending for dual eligibles; otherwise, lower.

<u>Rebalancing vulnerability</u>	<u>United States</u>	<u>Virginia</u>	
	<u>Number</u>	<u>Number</u>	<u>Rank</u>
Family Caregivers #/1000, Rank	137 ⁹⁰	150 ⁹¹	10 ⁹²
Value in \$Million/1000, Rank	\$1,460 ⁹³	\$1,480 ⁹⁴	29 ⁹⁵
Ratio, Rank	3.8 ⁹⁶	6.0 ⁹⁷	10 ⁹⁸

Virginia has a larger proportion of family caregivers than the national average, and the value they contribute is slightly higher than the national average. The value of family caregiving in Virginia compared to the commonwealth’s Medicaid long-term care spending is very high, ranking Virginia number 10 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 LTC services.⁹⁹

⁸⁶ *Ibid.*

⁸⁷ *Ibid.*

⁸⁸ 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>

⁸⁹ *Ibid.*

⁹⁰ 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>.

⁹¹ *Ibid.*, p. 323.

⁹² *Ibid.*

⁹³ *Ibid.*

⁹⁴ *Ibid.*, p. 323.

⁹⁵ *Ibid.*

⁹⁶ *Ibid.*

⁹⁷ *Ibid.*, p. 323.

⁹⁸ *Ibid.*

⁹⁹ "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,

Rebalancing also tends to increase overall Medicaid expenditures for long-term care, but these cost factors were captured above under “expenditure trends.”¹⁰⁰

<u>Managed care vulnerability</u>	<u>United States</u>	<u>Virginia</u>
Managed care for aged, blind and disabled recipients?	Expanding	Expanding
Managed care for “dual eligibles”?	Expanding	Expanding

Virginia is well along in the process of expanding managed care for ABD (aged, blind and disabled) recipients and for dual eligibles.

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.”¹⁰¹

Assign a weight and score for Medicaid’s viability as a LTC payer in the Table of Long-Term Care Vulnerability.

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

	<u>United States</u>	<u>Virginia</u> <u>Number</u>	<u>Rank</u>
Total Medicaid spending (2009)	\$368,330M ¹⁰²	\$5,806M	23
Five year % increase (2004-2009)	29% ¹⁰³	47%	7
Federal and state shares of Medicaid ¹⁰⁴	63.7% federal 36.3% state	43.0% ¹⁰⁵	

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.

¹⁰⁰ For details, see Stephen A. Moses, “Briefing Paper #4: Rebalancing Long-Term Care,” Center for Long-Term Care Reform, Seattle, Washington, 2011, www.centerlrc.com/BriefingPapers/4.htm.

¹⁰¹ 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.

¹⁰² 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. 327, <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>.

¹⁰³ *Ibid.*

¹⁰⁴ *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/>.

¹⁰⁵ Source provides no rank, only an alphabetical list of states.

Dependency on “provider taxes” ¹⁰⁶	Every state but Alaska ¹⁰⁷	1 tax, over 3.5% ¹⁰⁸
Social Security role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ¹⁰⁹	\$23.1 trillion ¹¹⁰	Vulnerable ¹¹¹
Medicare role in sustaining Medicaid (2013 infinite-horizon unfunded liability) ¹¹²	\$43.0 trillion ¹¹³	Vulnerable ¹¹⁴
Federal debt ¹¹⁵	\$16.7 trillion ¹¹⁶	Less vulnerable ¹¹⁷

¹⁰⁶ 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/>.

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.* Virginia has one provider tax which exceeds the 3.5% net patient revenue threshold so is vulnerable to a cut previously proposed.

¹⁰⁹ Although Social Security does not pay directly for long-term care, Medicaid does require LTC 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% as it has warned, the extra cost will fall directly on state Medicaid programs and LTC providers.

¹¹⁰ 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>.

¹¹¹ Potential cuts to Social Security benefits would not hurt Virginia’s 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.

¹¹² 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.

¹¹³ 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.”

¹¹⁴ 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.

¹¹⁵ “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

Virginia's Medicaid expenditures grew much more rapidly than the national average in the 2004-2009 review period. The commonwealth is less dependent on provider taxes than many other states, but its one tax exceeds the 3.5% threshold deemed vulnerable to future cuts in federal matching funds. Social Security benefit reductions or decreases in Medicare LTC provider reimbursement levels would severely impact Virginia's ability to fund its long-term care safety net, as would any deficit-related federal revenue retrenchment.

On average nationally, 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; otherwise, less.

Assign a weight and score in the Table of Long-Term Care Vulnerability for the reliability of federal funding to support Medicaid long-term care program.

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

Overview

"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.'"¹¹⁸

"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."¹¹⁹

"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."¹²⁰

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>.

¹¹⁶ U.S. National Debt Clock as of September 9, 2013, http://www.brillig.com/debt_clock/.

¹¹⁷ Virginia's relatively low FMAP makes the commonwealth somewhat less vulnerable to potential loss of federal funding than other states with higher FMAPs.

¹¹⁸ Maggie Clark, "States Pessimistic About Revenues In 2014," *Stateline*, August 13, 2013, http://www.pewstates.org/projects/stateline/headlines/states-pessimistic-about-revenues-in-2014-85899497318?utm_campaign=2013-08-14-stateline-daily.html&utm_medium=email&utm_source=Eloqua&elq=f72a55085fe642ada6d8aaa930074ae0&elqCampaignId=146.

¹¹⁹ 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.

¹²⁰ 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->

State Specific

<i>Rich States, Poor States</i> “Economic Competitiveness Index” ¹²¹		<u>Virginia Rank</u>
Economic Performance Rank	From Wyoming #1 to Michigan #50	8
Economic Outlook Rank	From Utah #1 to New York #50	3
<i>Forbes</i> Best States for Business and Careers ¹²²	From Utah #1 to Maine #50	1
Cato “Fiscal Policy Report Card,” ¹²³ 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	Bob McDonnell(R) score 50, grade C
Mercatus “Freedom Index” ¹²⁴ Combined personal/economic rank; change from 2009	From #1, North Dakota; +4 to #50, New York; 0% change	#8 +1
Tax Foundation ¹²⁵ State-Local Tax Burden	U.S. Average: 9.9%; Range: #1, New York, 12.8% to #50, Alaska, 7.0%	#30 9.3%
State Budget Shortfalls (2013) ¹²⁶	30+DC Yes	No ¹²⁷

Virginia’s economic prospects are excellent despite a relatively low Governor’s grade.

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.

¹²¹ 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.

¹²² “The Best States for Business and Careers,” *Forbes*, December 2012, <http://www.forbes.com/best-states-for-business/list/> ranked Virginia #2, but a September 2013 update returned the Commonwealth to #1: <http://www.forbes.com/best-states-for-business/list/>.

¹²³ 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)

¹²⁴ Mercatus Center, “Freedom in the 50 States,” list view, <http://freedominthe50states.org/>.

¹²⁵ 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>

¹²⁶ *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>.

¹²⁷ The source cited in footnote 127 for all states showed a \$145M shortfall expected for Virginia but the commonwealth ended the year with a surplus after all.

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.

Assign a weight and score in the Table of Long-Term Care Vulnerability for the reliability of a state's economy to support its Medicaid long-term care program.

6. How much private pay is available to relieve LTC financing pressure on Medicaid?

	<u>United States</u>	<u>Virginia</u>
Asset spend down potential ¹²⁸	Higher if easy eligibility can become less easy. ¹²⁹	Yes, after MOE ends. ¹³⁰
Estate recoveries (2004, latest data) ¹³¹		
Total	Total: \$361,766,396	\$776,866
As a % of nursing home spending	U.S. Average: 0.8%	0.1%
Range	From 5.8% (Oregon) ¹³² to 0.0% (Georgia)	
Home equity for LTC financing		
Medicaid home equity exemption ¹³³	From \$536,000 to \$802,000 as of 2013	\$536,000
Private long-term care insurance		
LTCI market penetration		
Private LTCI policies	6,485,598 ¹³⁴	243,465 ¹³⁵

¹²⁸ "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>.

¹²⁹ 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>.

¹³⁰ For example, after the maintenance of effort expires, Virginia DMAS should renew efforts to limit the use of life estates to qualify for Medicaid.

¹³¹ 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>.

¹³² The estate recovery table gives Arizona's collections as a percent of nursing home spending as 10.4%, 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."

¹³³ 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.

Policies per 1000 population	45 ¹³⁶	65, Rank 10
LTC partnership ¹³⁷	31 states approved	Yes
LTCI tax incentives ¹³⁸	36 states and DC	Carry through federal deduction + unique deduction + unique credit ¹³⁹

Virginia’s Medicaid long-term care financial eligibility criteria are already tighter than most states due to its 209-B status. Nevertheless, in the absence of the ACA’s maintenance of effort requirement, due to expire January 1, 2014, the state could tighten further as explained in the section on eligibility above. Virginia has an estate recovery program, but it could generate significantly higher revenue as explained above in that section. The state legislature opted for the lower home equity exemption cap mandated by the DRA ’05 of \$536,000. Private long-term care insurance market penetration is relatively high in Virginia. Although the commonwealth has a Long-Term Care Partnership Program, it has not been effectively promoted according to agents interviewed for this study. Virginia has strong state-level tax incentives for the purchase of private LTC 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.

Assign a weight and score in the Table of Long-Term Care Vulnerability for a state’s likelihood of generating private LTC financing to relieve the cost burden on Medicaid.

¹³⁴ 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>.

¹³⁵ *Ibid.*, p. 323.

¹³⁶ *Ibid.*

¹³⁷ 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>.

¹³⁸ 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>.

¹³⁹ Virginia is one of only three states with this comprehensive set of LTC insurance tax incentives. Source: *Ibid.* See p. 33 for details.

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

	<u>United States</u>	<u>Virginia</u>
Births financed by Medicaid (2010) ¹⁴⁰ Range:	47.8% From 69% in Louisiana to 24% in Hawaii	29.8%
Supplemental Nutrition Assistance Program (Food Stamps), 2012 ¹⁴¹		
Participants (ave. per month)	46,609,072	913,878
Percent of population ¹⁴²	14.8%	11.2%
Total annual benefits	\$74,619,344,626	\$1,403,720,773
Ave. benefit per person per month	\$133.41	\$128
Welfare exceeds minimum wage ¹⁴³	in . . . 35 states and ranges from \$5.36/hr. in Idaho to \$29.13 in Hawaii	\$7.15, Rank: 37
Social Security Disability Insurance (SSDI) replaces work ¹⁴⁴	\$144 billion, trust fund depleted in three years	
SSDI Beneficiaries, Ages 18-64 ¹⁴⁵	9,082,367	223,012
Percent of population ¹⁴⁶	2.9%	2.7%

¹⁴⁰ 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).

¹⁴¹ 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>.

¹⁴² 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>.

¹⁴³ "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.

¹⁴⁴ "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.

¹⁴⁵ *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/>.

¹⁴⁶ 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>.

Unfunded pension liabilities of state and local governments	\$3 trillion ¹⁴⁷	
To fully fund would require:	\$1,385 tax increase per household per year for 30 years ¹⁴⁸	\$1,066 tax increase per household per for 30 years. ¹⁴⁹
Nursing facility residents with . . . ¹⁵⁰		<u>Percent</u> <u>Rank</u>
Medicaid as primary payer,	63%	61% 33
Medicare as primary payer,	14%	19% 2
Other as primary payer	22%	20% 34
Medicaid recipients with prepaid burial plans that avoid spend down requirements	Approx. 80% ¹⁵¹	75% ¹⁵²

Virginia ranks well on all of the categories of “entitlement mentality.” Medicaid-financed births in the commonwealth are less than two-thirds of the national average. Food stamp participation, welfare payments compared to minimum wage, SSDI beneficiaries, unfunded pension liabilities, and nursing home residents dependent on Medicaid are all below the national average in Virginia.

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.

¹⁴⁷ Jeffrey A. Miron, “State and Local Pension Liabilities,” Cato Institute, July 17, 2013, <http://www.cato.org/blog/state-local-pension-liabilities>.

¹⁴⁸ “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>.

¹⁴⁹ *Ibid.*, Table 4--Required Increases for Full Funding by State, No Policy Change, p. 48.

¹⁵⁰ 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>.

¹⁵¹ 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.

¹⁵² Based on interviews with eligibility workers in three Virginia counties.

Worksheet of Long-Term Care Vulnerability

The following Excel 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 U.S. and your state based on data sources provided in this report or based on other data consistent across the country.

Table of Long-Term Care Vulnerability generic worksheet:



TLTCV 092513.xls

For example, the author has completed the following “Table of Long-Term Care Vulnerability” for the U.S. and Virginia. In time, we hope to have such worksheets available for every state in the country, 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.

Table of Long-Term Care Vulnerability for Virginia as completed by the author:



TLTCV 092513
Virginia.xls

Using this worksheet will allow those interested to see what the results will be as different variables detailed above are altered to try to predict the future values of these variables and how they impact the Long Term Care needs in the Medicaid system.

List of Interviewees

Althelia P. Battle, Deputy Commissioner, Life and Health Division, Commonwealth of Virginia State Corporation Commission, Richmond, Virginia (Submitted written answers to our questionnaire.)

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

Kathy Colley, Manager, Third Party Liability Unit, Fiscal and Purchasing Division, Department of Medical Assistance Services, Commonwealth of Virginia, Richmond, Virginia

Patricia Ford, Benefit Programs Manager, Powhatan County Department of Social Services, Powhatan, Virginia

Jill A. Hanken, Esq., Staff Attorney, Concentrating in Health Law, Virginia Poverty Law Center, Inc., Richmond, Virginia

Keith Hare, Deputy Secretary of Health & Human Resources, Office of the Governor, Richmond, Virginia

Hobart M. Harvey, Vice President Financial Services, Virginia Health Care Association, Richmond, Virginia

Joan Irwin, Supervisor, Nursing Home Care, Community Based Care Auxiliary Grants, County of Fairfax, Fairfax, Virginia

Cathy James, Benefit Programs Specialist, Powhatan County Department of Social Services, Powhatan, Virginia

Cindi B. Jones, MS, Director, Virginia Department of Medical Assistance Services, Richmond, Virginia

Olivia Jones, President, Virginia Association of Personal Care Providers, Richmond, Virginia

Josephine Kigo, Human Service Worker, Long Term Care Unit, County of Fairfax, Fairfax, Virginia

Karen Kimsey, Deputy Director, Complex Care Services, Department of Medical Assistance Services, Commonwealth of Virginia, Richmond, Virginia

Beth M. Ludden, Vice President, LTC Product, Genworth Financial, Richmond, Virginia

Jodi McAvenia, Eligibility Worker, Chesterfield-Colonial Heights, Department of Social Services, Chesterfield, Virginia

Stephen C. Morrisette, President, Virginia Health Care Association, Richmond, Virginia

Cindy Olson, Eligibility Section Manager, Division of Policy and Research, Department of Medical Assistance Services, Commonwealth of Virginia, Richmond, Virginia

Sandra H. Ovuka, Program Manager, Self Sufficiency Programs, County of Fairfax, Fairfax, Virginia

Dana Parsons, Legislative Affairs Legal Counsel, Virginia Association of Nonprofit Homes for the Aging (VANHA), Glen Allen, Virginia

Kathy Pryor, Elder Law Attorney, Virginia Poverty Law Center, Inc., Richmond, VA

Judy L. Redpath, CFP(r), AIF(r), VISTA Wealth Strategies LLC, Reston, Virginia

Evelyn Ross, Human Service Worker, Long Term Care Unit, County of Fairfax, Fairfax, Virginia

Margaret Ross Schultze, Commissioner, Department of Social Services, Commonwealth of Virginia, Richmond, Virginia

Mary Jane Skidmore, Operations Manager, Fairfax County, Department of Family Services, Fairfax, Virginia 22035

Marcia Tetterton, MS, CAE, Executive Director, Virginia Association for Home Care & Hospice, Richmond, Virginia

Nora Torres, Supervisor, Nursing Home Care, Community Based Care Auxiliary Grants, County of Fairfax, Fairfax, Virginia

Denise Weston, Benefit Program Supervisor, Chesterfield-Colonial Heights, Department of Social Services, Chesterfield, Virginia

About the Author

Stephen Moses is President of the Center for Long-Term Care Reform in Seattle, Washington (www.centerltc.com).

The Center promotes universal access to top-quality long-term care by encouraging private financing and discouraging welfare dependency for most Americans.

Previously, Mr. Moses was Director of Research for LTC, Inc., a Medicaid state representative for the Health Care Financing Administration and a senior analyst for the Inspector General of the U.S. Department of Health and Human Services. He is widely recognized as an expert and an innovator in the field of long-term care. *McKnight's Long-Term Care News* named Mr. Moses "one of the 100 most influential people in long-term care." *Nursing Homes* magazine reported "there is probably no more articulate spokesperson for privately financed long-term care than Stephen Moses." His articles have appeared in distinguished publications like *The Gerontologist*, *The Journal of Accountancy*, *The Journal of Financial Planning*, *Contemporary Long-Term Care*, and *National Underwriter*. He has published chapters in several long-term care anthologies. Steve Moses' recommendations are quoted frequently in the national media including the "CBS Evening News," PBS's "Frontline" and "The Financial Advisors," CNN, National Public Radio, *The New York Times*, *Newsweek*, *USA Today*, *Forbes*, *The New Republic*, *Smart Money*, *National Journal*, and Jane Bryant Quinn's syndicated column.

Mr. Moses has testified before Congress and two-thirds of America's state legislatures. He frequently addresses professional conferences in the fields of law, aging and insurance. He is currently working on a book for the Cato Institute provisionally titled "Long-Term Care: The Preventable Tragedy." Contact him at smoses@centerltc.com or 206-283-7036.

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John Hager: Former Lt. Governor of Virginia.

Robert L. Hartwell: President, Hartwell Capitol Consulting.

Alan I. Kirshner: Chairman and CEO of Markel Corporation.

Jay Poole: Retired Vice President for Agriculture Policy and Programs, Altria Corp. Services

Joseph Ragan: Founder and President of Joe Ragan's Coffee.

John Rust: Former State Delegate and Partner, Rust and Rust law firm.

John Ryan: Former Senior Counsel and Director of Gov't Affairs for Bristol Myers Squibb.

Robert W. Shinn: President of Public Affairs, Capitol Results

Todd A. Stottlemeyer: CEO, Interactive Technology Solutions

Dr. Robert F. Turner: Law professor at the University of Virginia at Charlottesville.

Robert W. Woltz, Jr: Retired President and CEO of Verizon-Virginia.



“... a wise and frugal government, which shall restrain men from injuring one another, shall leave them otherwise free to regulate their own pursuits of industry and improvement, and shall not take from the mouth of labor the bread it has earned. This is the sum of good government, and this is necessary to close the circle of our felicities.”

Thomas Jefferson, 1801

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