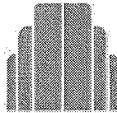


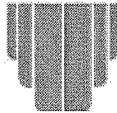
# **The Maine Thing About Long-Term Care**

## **Is That Federal Rules Preclude a High-Quality, Cost-Effective Safety Net**

presented by the



CENTER FOR  
LONG-TERM CARE  
REFORM



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

With support from the



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Stephen A. Moses, President  
Center for Long-Term Care Reform  
2212 Queen Anne Avenue North, #110  
Seattle, Washington, 98109  
Email: [smoses@centerltc.com](mailto:smoses@centerltc.com)  
Web: <http://www.centerltc.com>

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## **The Maine Thing About Long-Term Care Is That Federal Rules Preclude a High-Quality, Cost-Effective Safety Net**

### **Preface**

The Maine Health Care Association (MHCA)<sup>1</sup>--a trade and professional organization for long-term care providers--contracted with the Center for Long-Term Care Reform (CLTCR)<sup>2</sup>--an independent, non-partisan research institute--to conduct a study of Medicaid and long-term care financing in Maine. Center president Stephen Moses interviewed staff of the Maine Department of Health and Human Services (DHHS) and representatives of key interest groups during a field visit, October 1-5, 2012, to Augusta and Portland. Interviewees are listed in the Appendix. Each study participant will receive an electronic copy of this report. Anyone else may obtain a copy by request to [info@centerltc.com](mailto:info@centerltc.com) or by downloading it from <http://www.centerltc.com/reports.htm>.

The problems and challenges addressed in this report are not new. The following observations are from a 1993 report sponsored by the Maine Department of Human Services and the Maine Health Care Association.

Maine is about \$1 billion short of revenue. Cuts in the nursing home budget are expected to fill about \$20 million of this gap. The state's whole Medicaid budget for nursing homes, however, is only \$81 million. So, the cuts being considered are truly draconian--almost 25 percent. But this isn't even the half of it: when the federal match is added, cuts in projected nursing home expenditures total \$55 million out of a combined state and federal budget of \$218 million.<sup>3</sup>

The 1993 report cited reasons for that earlier budget shortfall:

Maine has one of the most generous medical welfare programs in the country. The state not only covers most optional Medicaid services, but eligibility for people who need nursing home care is extremely easy. Eighty percent of all residents in Maine's nursing homes are already covered by the Medicaid program. The remaining 20 percent could be on Medicaid within 30 days (days, not months!) if they chose to hire one of the attorneys we interviewed or to buy one of the self-help guides we discussed. In fact, stunned and frustrated state Medicaid eligibility workers told us that people are actually immigrating from New Hampshire (where Medicaid rules are much tougher) to take advantage of Maine's easy access to high quality publicly-financed care. They said: "We used to

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<sup>1</sup> The Maine Health Care Association's website is [www.mehca.org](http://www.mehca.org).

<sup>2</sup> The Center for Long-Term Care Reform's website is [www.centerltc.com](http://www.centerltc.com).

<sup>3</sup> Stephen A. Moses, "Medicaid Estate Recoveries in Maine: Planning to Increase Non-Tax Revenue and Program Fairness," LTC Incorporated, Kirkland, Washington, March 22, 1993; [http://centerltc.com/pubs/Medicaid\\_Estate\\_Recoveries-Maine-1993.pdf](http://centerltc.com/pubs/Medicaid_Estate_Recoveries-Maine-1993.pdf).

see \$40,000 shelters. Now they are \$500,000." Middle class Medicaid in Maine is hemorrhaging red ink for nursing home care at the same time that state revenues preclude full financing of medical care for poor women and children, education and infrastructure.<sup>4</sup>

The findings, conclusions and recommendations in the following report are disturbingly similar to those of the earlier report. With the baby-boomer age wave 19 years closer to impact, MaineCare and federal Medicaid face a greater urgency than ever to pursue the needed corrective actions.

### **Executive Summary**

The probability of needing long-term care (LTC) after age 65 is high (69%) and potentially very expensive (20% require five years or more).<sup>5</sup> Maine already has a relatively old and rapidly aging population including a baby-boomer bulge that will require much costlier LTC in the future.

Most expensive LTC is paid for by Medicaid, a means-tested public assistance program, jointly financed by the federal and state governments. Medicaid in Maine is called MaineCare. It faces severe financial challenges, of which funding high-quality LTC is the most serious.

MaineCare covers 2/3 of nursing home residents, but pays only 69% of the private-pay rate for care of some of the highest acuity patients in the USA. Likewise, MaineCare's reimbursement rate for its popular assisted living program, one of the largest in the country, is only half of the private rate.

State revenues are flat or falling while MaineCare expenses continue to rise, creating a well-publicized budget crisis. Solutions are few. Further cutting providers bodes ill for LTC access and quality, but reducing benefits for the poor or robbing education to make budget ends meet are also objectionable.

Our analysis of the LTC financing challenge in Maine suggests a different approach to the problem. Many people assume that any effort to reduce MaineCare expenditures constitutes an attack on the poor. Yet, we found in this study that MaineCare LTC benefits are readily available to the middle-class, affluent and even the wealthy.

We verified practices that allow MaineCare LTC applicants to protect hundreds of thousands of dollars without penalty immediately before becoming eligible. We verified

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<sup>4</sup> *Ibid.*

<sup>5</sup> "While an estimated 31% of people currently turning 65 will not need any LTC before they die, 20% will need care for more than five years." (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. 341-2; [http://www.inquiryjournal.org/.](http://www.inquiryjournal.org/))

official policies that ensure virtually anyone can qualify quickly for MaineCare's LTC benefits due to exorbitantly generous income and asset exemptions.

Are MaineCare officials at fault in this regard? Not at all. They are constrained by federal laws and regulations that compel them to enforce these easy-eligibility policies. In past years, Maine had some flexibility within the generous federal eligibility policies to tighten up in certain ways. No longer. Because of the health reform law's "maintenance of effort" (MOE) requirement, MaineCare is locked into its most generous policies that were adopted in better economic times.

Options are few. The state can recover more forcefully from the estates of deceased recipients and their spouses because MOE does not apply there. Public officials could encourage people to plan to pay privately for LTC with insurance or home equity conversion. But "jawboning" responsible consumer behavior will likely have little impact as long as people can ignore LTC risk and cost and still protect ¾ of a million dollars of home equity, use annuities to shelter unlimited assets and retain many other resources without limit.

Even if Maine successfully challenges the MOE rule, the state will remain constrained by federal law to enforce extremely generous federal eligibility policies. Maine could request a waiver of federal law on an experimental basis to tighten eligibility policies, but no such waiver has ever been requested before, much less granted.

Under current constraints the only option to solve the problem fully is to defy the counterproductive federal rules, independently implement eligibility policies that target scarce public LTC resources to the truly needy, risk losing federal Medicaid matching funds, and challenge federal officials to defend the objectionable policies that rob LTC benefits from the poor and shower them on the well-to-do.

Short of such civil disobedience, Maine's most promising strategy is to redouble efforts to escape the MOE constraints and implement the recommendations listed at the end of this report.

### **The National Issue**

Long-term care (LTC) is custodial and/or medical attention individuals need for 90 days or more when they are unable to manage their own activities of daily living (ADLs)<sup>6</sup> without help. Individuals of any age may require LTC, but we focus here on the frail or infirm elderly. Families provide most LTC in their own homes for free.<sup>7</sup> Heavier custodial or medical LTC provided by nurse aides, nurses, primary physicians or

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<sup>6</sup> Principal ADLs are dressing, eating, ambulating, toileting, and hygiene.

<sup>7</sup> Family caregivers in Maine contribute \$2.3 billion worth of free care per year, valued at \$12.50 per hour. The economic value of family caregiving in Maine is 3.2 times the cost of MaineCare's LTC spending. (Source: Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, "Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012," AARP, Washington, DC, 2012, p. 157; <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>.)

geriatricians is extremely expensive.<sup>8</sup> Aging baby boomers—America’s “Age Wave”—guarantee that the need and cost of LTC will increase rapidly in the future.<sup>9</sup> Most expensive LTC is financed nationwide through Medicaid, a means-tested public assistance program, and Medicare.<sup>10</sup> Medicaid, especially its LTC component, is already a tremendous strain on federal and state budgets. The ability of Medicaid to finance much higher LTC expenditures in the future is doubtful. Yet, alternative private LTC financing sources are minimal now and declining. Finding ways to finance quality LTC in the most appropriate care settings is a critical challenge across the United States. Maine is no exception.

## Maine’s LTC Profile

If anything, Maine’s LTC financing challenge is greater than most states’. Mainers 85 years or older—the age cohort most likely to require LTC—already comprise 2.4% of the population making Maine the eighth oldest state. By 2032, 3.5% of them will join the “oldest old,” ranking the state third oldest in the nation. Maine has the highest proportion of nursing home residents with dementia of any state (55%) and the 49<sup>th</sup> lowest percentage of residents with low care needs (2%). The state ranks eighth in the number of assisted living and residential care facilities per thousand elderly people.<sup>11</sup>

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<sup>8</sup> The national median daily rate for a nursing home is \$200 (semi-private room) and \$222 (private room). For Maine, the figures are \$264 and \$288 respectively. The national median monthly rate for assisted living is \$3,300, but \$4,500 for Maine. Even home health aide charges are very expensive at \$19 per hour (\$22 per hour in Maine) when more than a few hours per day are needed. (Source: Genworth 2012 Cost of Care Survey,

[http://www.genworth.com/content/etc/medialib/genworth\\_v2/pdf/ltc\\_cost\\_of\\_care.Par.40001.File.dat/2012%20Cost%20of%20Care%20Survey%20Full%20Report.pdf](http://www.genworth.com/content/etc/medialib/genworth_v2/pdf/ltc_cost_of_care.Par.40001.File.dat/2012%20Cost%20of%20Care%20Survey%20Full%20Report.pdf).)

<sup>9</sup> Americans aged 85+, the cohort most likely to need LTC, will increase from 2% of the population in 2012 to 4.8% by 2050. (Source: Ari Houser, Wendy Fox-Grage, Kathleen Ujvari, “Across the States: Profiles of Long-Term Services and Supports, Ninth Edition 2012,” AARP, Washington, DC, 2012, p. 156; <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>.)

<sup>10</sup> America spent \$143.1 billion on nursing facilities and Continuing Care Retirement Communities in 2010. The percentage of these costs paid by Medicaid and Medicare has gone up over the past 40 years (from 26.8% in 1970 to 53.8% in 2010, up 27.0 % of the total) while out-of-pocket costs have declined (from 49.5% in 1970 to 28.3% in 2010, down 21.2% of the total). (Source: Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>, Table 12.) The situation with home health care financing is very similar to nursing home financing. According to CMS, America spent \$70.2 billion on home health care in 2010. Medicare (44.9%) and Medicaid (37.3%) paid 82.2% of this total and private insurance paid 6.4%. Only 7.1% of home health care costs were paid out of pocket. The remainder came from several small public and private financing sources. (Source: Centers for Medicare and Medicaid Services, <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf>, Table 4.) For analysis of the ramifications of these facts, see Stephen A. Moses, “LTC Bullet: So What If the Government Pays for Most LTC?, 2010 Data Update,” Center for Long-Term Care Reform, January 13, 2012; <http://www.centerlrc.com/bullets/archives2012/941.htm>.

<sup>11</sup> The preceding data come from 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. 156-161; <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>.

Public financing dominates LTC in Maine. Two-thirds of the state's nursing home residents rely primarily on Medicaid, 3% more than the national average. Medicare covers 16% of the residents, 2% more than nationally. Only 18% rely on other financing sources, including private pay, which is 4% less than the national average.<sup>12</sup> Dependency on public funds is even higher for Maine's assisted living facilities, with upwards of 80% covered through the Private Non-Medical Institutions (PNMI) program,<sup>13</sup> as estimated by LTC providers interviewed for this study.

Medicaid already consumes 23.1% of the state budget, over \$1.4 billion for the FY '12-'13 biennium. It's projected to increase to 23.5% and \$1.6 billion in FY '14-'15.<sup>14</sup> For every dollar Maine invests in Medicaid, it gets almost two more from the federal government to spend on the program.<sup>15</sup> Long-term care consumes nearly one-third of Maine's Medicaid expenditures, 31.4%.<sup>16</sup> Of this, roughly one-third (32.9%) funds nursing homes and half (52.0%) pays for more popular home health and personal care services.<sup>17</sup>

MaineCare's expenditures for long-term care have moderated over the past few years compared to average LTC spending nationwide, especially in the area of home and community-based services. For example, overall MaineCare spending for older people and adults with physical disabilities increased only 4% from 2004 to 2009 compared to 28% for the country as a whole. HCBS spending for older people and adults with physical disabilities was up only 8% compared to the US total of 70% in the same period. MaineCare HCBS spending as a percentage of total LTC spending for the same group was up only 1% compared to 9% for the US.<sup>18</sup>

### **Maine's LTC Financing Crisis**

If MaineCare's LTC financing growth has moderated somewhat in recent years, why does the state nevertheless face a severe challenge funding LTC services? The looming wave of aging baby boomers bodes poorly for the future, of course, but

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<sup>12</sup> *Ibid.*, p. 160.

<sup>13</sup> For more information on the PNMI program, see <http://www.maine.gov/dhhs/oms/provider/pnmi.html>.

<sup>14</sup> Department of Administrative & Financial Services, Bureau of the Budget, "State of Maine Revenue and Expenditure Projection: General Fund and Highway Fund, Fiscal Years 2012 – 2015," Augusta, Maine, September 28, 2012, p. 12; <http://www.maine.gov/budget/budgetinfo/Sept2012RevExpForecast9-28-12.pdf>.

<sup>15</sup> Maine's FMAP for 2013 will be 62.57%, down from 74.35% in 2009 and 74.86% in 2010. (Source: StateHealthFacts.org, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier"; <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4>).

<sup>16</sup> StateHealthFacts.org, "Distribution of Medicaid Spending by Service, FY2010"; <http://www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4>.

<sup>17</sup> StateHealthFacts.org, "Distribution of Medicaid Spending on Long Term Care, FY2010"; <http://www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4>.

<sup>18</sup> 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. 161; <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>.

MaineCare director Stefanie Nadeau described the immediate problem this way.<sup>19</sup> The state's general fund is at a "tipping point." Revenues have been flat or falling for several years with no end in sight for budget shortfalls. Unless ways can be found to control MaineCare expenses, the program's cost overages will have to be taken from other state priorities. Education, the state's biggest spending category, is the most likely candidate for reductions to cover MaineCare growth. Yet no one wants to see education cut to finance growing MaineCare LTC expenditures for the elderly.

The challenge for MaineCare's LTC program is to find creative ways to do more with less. Savings from using limited resources more wisely could go toward shielding the education budget from cuts, toward reducing MaineCare's waiting lists for MR/DD services, toward paying LTC caregivers sufficiently to ensure their availability and quality, and toward other desirable goals currently unaffordable. What's stopping MaineCare from implementing such cost-effective reforms? The program is tied in knots by federal laws and regulations that prevent MaineCare from curbing wasteful and expensive federally mandated policies.

### **Maintenance of Effort: How Federal Medicaid Impacts MaineCare**

MaineCare had generous financial eligibility rules for LTC before the American Recovery and Reinvestment Act of 2009 (ARRA '09, AKA "the stimulus")<sup>20</sup> granted substantial Federal Medical Assistance Percentage (FMAP)<sup>21</sup> bonuses to all states (\$600 million over three years to Maine). To qualify for this additional revenue, the state Department of Health and Human Services had to agree not to tighten eligibility for MaineCare LTC. This "maintenance of effort" (MOE) requirement prevented Maine from reducing expenditures during the economic downturn by means of targeting scarce resources to the most needy applicants.

The ARRA '09's MOE restriction expired at the end of June 2011, at which time Maine's FMAP collapsed from over three federal dollars for every one state dollar (75.86% in 2010) to less than two federal dollars for every one state dollar (63.80% in 2011).<sup>22</sup> By then, however, a new MOE rule applied. The Patient Protection and

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<sup>19</sup> Stephen Moses interviewed MaineCare Director Stefanie Nadeau and Policy and Program Director Bethany L. Hamm on October 2, 2012.

<sup>20</sup> "The **American Recovery and Reinvestment Act of 2009**, abbreviated **ARRA** (Pub.L. 111-5) and commonly referred to as **the Stimulus** or **The Recovery Act**, is an economic stimulus package enacted by the 111th United States Congress in February 2009 and signed into law on February 17, 2009, by President Barack Obama." (Source: Wikipedia, [http://en.wikipedia.org/wiki/American\\_Recovery\\_and\\_Reinvestment\\_Act\\_of\\_2009](http://en.wikipedia.org/wiki/American_Recovery_and_Reinvestment_Act_of_2009).)

<sup>21</sup> The Federal Medical Assistance Percentage or FMAP is the percentage of MaineCare spending provided by the federal government. For example, at a 75% FMAP, MaineCare would receive \$3 from the federal government for every dollar the state of Maine invests in MaineCare. At a 66% FMAP, Maine would receive only \$2 for each dollar it contributes. Reductions in FMAP can devastate state budgets, as happened to Maine with the expiration of the ARRA '09 FMAP bonus.

<sup>22</sup> StateHealthFacts.org, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier"; <http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4>.

Affordable Care Act of 2010 (PPACA, AKA health reform or “ObamaCare”)<sup>23</sup> required maintenance of effort upon penalty of the loss of all federal Medicaid funds. Under PPACA, however, the state received no bonus FMAP for complying with MOE. Thus, with flat or falling state revenue, Maine is locked into retaining some of the most generous Medicaid LTC financial eligibility rules in the United States.

The United States Supreme Court ruled last summer that ObamaCare is constitutional but that states could opt out of its Medicaid expansion provision without losing federal matching funds for the rest of their Medicaid programs.<sup>24</sup> Arguably, states that do not expand Medicaid under PPACA should not be constrained by the law’s MOE provision for the same reason. The state of Maine has made that case, but so far unsuccessfully based on interpretations from the Centers for Medicare and Medicaid Services (CMS, the federal agency that oversees Medicaid) and the Congressional Research Service.<sup>25</sup>

Faced with a severe budget shortfall and doubtful new revenue sufficient to close the gap, MaineCare has only three ways to constrain costs: cut benefits, cut providers or cut eligibility. With eligibility cuts out of bounds due to MOE, the state’s only options, besides shifting funds from education or some other budget category, are to eliminate desperately needed services or to reduce provider reimbursements. Cutting services hurts the most needy. Provider reimbursements are already minimal and further cuts could lead to additional facility closures and LTC provider shortages.

On the other hand, limiting eligibility for LTC, MaineCare’s most expensive benefit, could save the state a lot of money and contribute greatly toward closing the budget shortfall without hurting, and in many respects, helping Mainers most in need. By

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<sup>23</sup> “The **Patient Protection and Affordable Care Act (PPACA)**,<sup>[1]</sup> commonly called **Obamacare**<sup>[2][3]</sup> (or the **federal health care law**), is a **United States federal statute** signed into law by **President Barack Obama** on March 23, 2010. Together with the **Health Care and Education Reconciliation Act**, it represents the most significant regulatory overhaul of the **U.S. healthcare system** since the passage of **Medicare and Medicaid** in 1965.<sup>[4]</sup>” (Source: Wikipedia,

[http://en.wikipedia.org/wiki/Patient\\_Protection\\_and\\_Affordable\\_Care\\_Act](http://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act).)

<sup>24</sup> “**National Federation of Independent Business v. Sebelius**, 567 U.S. \_\_\_\_ (2012), was a landmark<sup>[2][3][4][5][6]</sup> **United States Supreme Court** decision in which the Court upheld Congress' power to enact most provisions of the **Patient Protection and Affordable Care Act (ACA)** and the **Health Care and Education Reconciliation Act (HCERA)**, including a requirement for most Americans to have health insurance by 2014.<sup>[7][8][9][10]</sup>” (Source: Wikipedia,

[http://en.wikipedia.org/wiki/National\\_Federation\\_of\\_Independent\\_Business\\_v.\\_Sebelius](http://en.wikipedia.org/wiki/National_Federation_of_Independent_Business_v._Sebelius).)

<sup>25</sup> In a “Dear Governor” letter dated July 10, 2012, USDHHS Secretary Kathleen Sebelius wrote: “The Supreme Court held that, if a state chooses not to participate in this expansion of Medicaid eligibility for low-income adults, the state may not, as a consequence, lose federal funding for its existing Medicaid program. The Court’s decision did not affect other provisions of the law.” The letter to Governors is available online here: <http://capsules.kaiserhealthnews.org/wp-content/uploads/2012/07/Secretary-Sebelius-Letter-to-the-Governors-071012.pdf>. A July 16, 2012 Congressional Research Service Memorandum reached the same conclusion: “A careful reading of the Court’s holding supports the conclusion that [the maintenance of effort provision is] unaffected by the Supreme Court’s ruling, and [is] enforceable under the current Medicaid statute.” The CRS Memo is available here: <https://docs.google.com/file/d/0B61rrpmRSrQWV0paN3dSa21WbEE/edit?pli=1>.

explaining why this is true and how it can be done, we hope to help Maine make the case to CMS for relief from the MOE restrictions.

## **Federal LTC Eligibility Rules and MaineCare Policy**

Federal rules governing Medicaid LTC financial eligibility are mandatory and generous, but in the absence of MOE restrictions, they do allow states some flexibility. To qualify for benefits, applicants must fall within certain income and asset limits.

### **Income Limits**

Most states, including Maine, apply a “medically needy” income standard. That means that medical expenses not covered by Medicare, including the cost of LTC, are deducted from the applicant’s income before determining eligibility. Consequently, *income is almost never an obstacle to eligibility* because applicants’ incomes are nearly always insufficient to cover all such deductible costs. Thus, to be eligible for MaineCare LTC, individuals do not need to be “low income” as is often reported. They only need to have a cash flow problem, *i.e.*, insufficient income to pay the enormous monthly expenses caused by extensive medical and LTC services.

Some states use a different, stricter “income cap” eligibility standard. To qualify, applicants in income cap states must have incomes below 300% of the Supplemental Security Income (SSI) monthly payment, which is \$698 for 2012 giving an income cap of \$2,094 for the current year. Although it is true that since the Medicare Catastrophic Coverage Act of 1988 (MCCA ’88) legalized them, applicants in income-cap states may use “Miller income diversion trusts” to reduce their income and qualify, eligibility under the income cap standard is, nevertheless, marginally tougher than under medically needy systems like Maine’s.

Maine opted for the more generous “medically needy” income eligibility standard in better economic times. Because of PPACA’s maintenance of effort requirement, the state cannot retrench to the less expensive “income cap” standard now.

### **Asset Limits**

Federal asset limits for LTC eligibility are also generous and elastic. Most states permit Medicaid recipients to retain only \$2,000 in cash or negotiable financial instruments. MaineCare chose to be more generous, allowing \$10,000. Less commonly realized, however, is that federal rules allow recipients to retain:

- Equity in one home, including all contiguous property, of up to a \$525,000 minimum. Maine allows a \$750,000 home equity exemption, almost the maximum permitted under federal law of \$786,000.<sup>26</sup>

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<sup>26</sup> The Deficit Reduction Act of 2005 established the first ever limits on home equity for Medicaid eligibility. Originally set at a minimum of \$500,000 and a maximum of \$750,000, the limits were scheduled to increase annually with inflation. Thus, as of 2012, the minimum is \$525,000 and the

- The capital and cash flow in one income-producing business<sup>27</sup>
- Unlimited home furnishings and personal belongings<sup>28</sup>
- One automobile of unlimited value<sup>29</sup>
- Unlimited pre-paid burial plans<sup>30</sup>
- Unlimited term life insurance<sup>31</sup>
- Individual retirement accounts assets and pensions in the applicant's or recipient's (AR) names as long as the AR is receiving periodic interest and principal payments.<sup>32</sup>

Because of these generous asset exemptions, MaineCare LTC applicants can easily reconfigure their non-exempt resources to make them non-countable and themselves eligible.

Due to PPACA's maintenance of effort requirement, the state cannot retrench to the lower home equity limit nor implement other more restrictive limits on exempt assets. Consequently, eligibility for MaineCare's most expensive LTC benefit remains readily available to people who should, could and would have funded their own care, at least for some period of time, in the absence of such easy access to MaineCare benefits.

### **Spousal Impoverishment Protections**

Eligibility for members of a married couple is even more generous. Federal law provides that the healthy spouse in the community may retain up to half the couple's joint

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maximum is \$786,000. Later clarification by CMS made it clear, however, that states may "elect a home equity limit that is greater than \$500,000 as adjusted by inflation, but that does not exceed \$750,000, as adjusted by inflation." Under this authority, Maine has not increased its original \$750,000 home equity exemption to reflect inflation. (Source: CMS, "New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005," <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf>.)

<sup>27</sup> "Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective May 1, 1990." Social Security Administration, Program Operations Manual System (POMS), <http://policy.ssa.gov/poms.nsf/lnx/0501130501>.

<sup>28</sup> "Based on a change in the regulations effective March 9, 2005, the resource exclusion for household goods and personal effects was changed to eliminate the dollar limit of the exclusion." Social Security Administration, POMS, "SI 01130.430: Household Goods, Personal Effects and Other Personal Property," <http://policy.ssa.gov/poms.nsf/lnx/0501130430>.)

<sup>29</sup> "One automobile per household is excluded regardless of the value if it is used for transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. ASSUMPTION: Assume the automobile is used for transportation, absent evidence to the contrary." Social Security Administration, POMS, "SI 01130.200: Automobiles and Other Vehicles Used for Transportation," <http://policy.ssa.gov/poms.nsf/lnx/0501130200>. (Emphasis in the original.)

<sup>30</sup> "A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value." Social Security Administration, POMS, "SI 01130.400: Burial Spaces," <http://policy.ssa.gov/poms.nsf/lnx/0501130400>.

<sup>31</sup> "[T]he FV [face value] of the following are not taken into account: burial insurance policies; and term insurance policies that do not generate a CSV [cash surrender value]." Social Security Administration, POMS, "SI 01130.300: Life Insurance," <http://policy.ssa.gov/poms.nsf/lnx/0501130300>.

<sup>32</sup> Social Security Administration, POMS, "SI 01120.210 Retirement Funds," <https://secure.ssa.gov/apps10/poms.nsf/lnx/0501120210>.

assets not to exceed \$113,640. Maine, however, adopted this federal maximum as its minimum, thus allowing community spouses of institutionalized MaineCare recipients to retain all their joint assets up to the full amount of \$113,640.<sup>33</sup> Federal “spousal impoverishment”<sup>34</sup> provisions also protect the community spouse’s income level. If the community spouse lacks sufficient income otherwise, the institutionalized spouse’s income may be transferred to bring her (or him) up to a monthly minimum of \$2,841.

Because of PPACA’s maintenance of effort requirement, Maine cannot retrench to the lower spousal impoverishment standard otherwise allowable under federal law.

### **MaineCare Planning**

Beyond these relatively easy federal income and asset limits as expanded further by previous MaineCare policy, it is possible to apply techniques of artificial self-impoverishment to qualify people with even greater wealth for LTC benefits. Some lawyers and other financial specialists assist families to reduce their otherwise disqualifying income and/or assets to levels that enable applicants to qualify for benefits. Among the more egregious MaineCare planning methods are asset transfers for home care and assisted living; Medicaid-compliant annuities, which allow hundreds of thousands of dollars to be divested immediately before eligibility is granted; and the reverse half-a-loaf strategy.

*Asset transfer penalties* apply under federal law for institutional care.<sup>35</sup> Applying asset transfer penalties for home and community-based services (HCBS) is voluntary for state Medicaid programs. MaineCare chose to penalize asset transfers for the purpose of qualifying for HCBS, but only on the state-only room and board portion of the benefit. The care portion of the benefit, for which the state receives federal matching funds, has no transfer of assets penalty. The financial impact of this policy may be significant and should be determined and corrected if substantial.

*The use of annuities to qualify affluent Mainers, even “millionaires” according to eligibility workers interviewed for this study, is pervasive.* This technique is used in two ways. For married applicants, the couple’s otherwise disqualifying wealth is transferred into an annuity for the community spouse strictly in keeping with allowable federal guidelines, which require actuarial soundness and making the state the beneficiary of

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<sup>33</sup> For example, under the more restrictive standard, a couple with combined assets of \$120,000 would be able to retain only \$60,000. The remaining \$60,000 would need to be spent down before Medicaid eligibility would be granted. Under Maine’s more generous standard, the same couple retains the full \$113,640 and faces only a \$6,360 spend down requirement.

<sup>34</sup> These federal spousal impoverishment protections were established in the Medicare Catastrophic Care Act of 1988 (MCCA ’88): The Community Spouse Resource Allowance (CSRA) of half the joint assets not to exceed \$60,000 and a Monthly Maintenance Needs Allowance for the community spouse of up to \$1,500 per month. These limits increased with inflation annually to their current levels of \$113,640 and \$2,841, respectively.

<sup>35</sup> The “transfer of assets” penalty in months of ineligibility is calculated by dividing the total amount of assets transferred for less than fair market value for the purpose of qualifying for Medicaid by the average cost of a nursing home in the state.

residual funds. Virtually any amount of money can be transferred into such an annuity rendering the institutionalized applicant immediately eligible. The annuity pays out to the community spouse within the life expectancy of the institutionalized spouse, often in less than one year. Workers cited one example of a \$450,000 annuity which paid out at a rate of \$17,000 per month until all the sheltered funds were back with the community spouse and hence uncounted, the eligibility determination having already been made.

The second way annuities are used to qualify otherwise ineligible applicants for MaineCare involves single people with excess assets. The “reverse half-a-loaf”<sup>36</sup> strategy works as follows. The applicant gives away half his or her disqualifying assets thus creating an eligibility penalty equal to the amount of assets transferred for less than fair market value divided by the average cost of a nursing home in Maine. With the other half of the assets, the applicant creates an annuity in his or her own name and uses the proceeds of the annuity to pay for care during the duration of the penalty period. When the penalty period expires, the annuity runs out, and the applicant is eligible for MaineCare LTC benefits having protected half the original assets from MaineCare’s spend down requirement.

### **The Cost of MaineCare Compliant Annuity Abuse**

How big a financial impact do annuities have on MaineCare costs? State staff report that in 2011, 46 annuities totaling \$5,847,488 were approved averaging \$127,119 over a payback period of 20.07 months on average with a total return of \$5,911,035 to the annuitants, whose average age was 82. So far in 2012, 25 annuities have been approved totaling \$3,443,147 and averaging \$137,726 over a payback period of 23.24 months and with a total payback to the annuitants of \$3,473,953. Eligibility staff are supposed to refer all annuities to a headquarters expert who keeps track of them. That expert<sup>37</sup> opines, however, that because the workers are so busy and because they know the annuities, which are set up by legal and financial experts, are going to be allowed anyway, he believes that all the annuities are not reported or tracked.

In a March 10, 2010 letter, Director Ann Clemency Kohler of the National Association of State Medicaid Directors asked Cynthia Mann, Director of the CMS Center for Medicaid and State Operations to specify that “these annuities are trusts and that under the trust rules, the entire purchase price – which must be paid back to the community spouse to avoid a transfer penalty – is an available resource.” Otherwise such annuities “shelter resources and assets from being properly counted under the medicaid eligibility rules” with the result that a “couple can protect literally any amount – even \$1

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<sup>36</sup> Before the DRA '05 changed the rule, transfer of asset penalties were calculated starting with the date of the transfer. Thus, with just a little foresight families could take half a frail or infirm elder’s money, delay expensive LTC as long as possible, and minimize or avoid spending any personal funds. This “half-a-loaf” strategy was the most pervasive method of Medicaid planning at the time. The DRA '05 ended the practice by starting the penalty period at the date the individual would have otherwise have become eligible before the rule change. Elder law attorneys developed the “reverse half-a-loaf” strategy described in the text to circumvent and defeat the intent of Congress in stopping the half-a-loaf strategy.

<sup>37</sup> Reinhold “Ron” Bansmer, Special Projects Program Manager, DHHS, Augusta.

million – of resources.” According to MaineCare staff, CMS did not respond formally to the Medicaid Directors’ letter. Consequently, the practice continues.

According to MaineCare eligibility staff, one company “Employees Life Company (Mutual)” of Illinois and one agent, Mr. Dale Krause of De Pere, Wisconsin, supplied most of the annuities used to qualify wealthy individuals for MaineCare. According to his website: “For more than 25 years, Dale M. Krause, J.D., LL.M., has provided Medicaid Compliant Annuities to elder law attorneys, and their clients, throughout the United States. As a result of his practice, Mr. Krause has been labeled ‘The Pioneer of Medicaid Compliant Annuities.’”<sup>38</sup>

### **Availability of MaineCare Planning Services**

MaineCare planning services are readily available throughout the state of Maine. An internet search for “Medicaid planning in Maine” yields many examples, such as this one:

[T]he attorneys at the Maine Center for Elder Law, LLC often assist seniors in implementing plans that can go a long way toward protecting assets in case of future need for assisted living or nursing home care. Done early enough and if there are honest, reliable family members or others involved, such ‘pre-planning’ can save a large fraction of the seniors’ assets.<sup>39</sup>

Training classes on do-it-yourself MaineCare planning are also available:

PLANNING FOR MAINECARE ELIGIBILITY: Gain an understanding of the MaineCare rules for assisted living and nursing home care. You will also learn about planning opportunities, important documents that every person should have and whether you are making accidental gifts.<sup>40</sup>

Maine Governor LePage complained about easy Medicaid eligibility rules and Medicaid planning abuses to members of Congress who solicited his comments on their “Medicaid Long-Term Care Reform Act (H.R. 6300).”<sup>41</sup> His October 15, 2012 letter stated that Medicaid’s minimum \$525,000 home equity exemption “appears to be an extremely high threshold;” that the home should not remain exempt if “the individual is institutionalized and will not be able to return home” which would require a “change in the ‘intent to return’ provision;” that “regulations should be simplified so that States can deny Medicaid to all people who have transferred resources to become eligible for

<sup>38</sup> Cited October 26, 2012 at <http://medicaidannuity.com/About/DaleKrause/tabid/63/Default.aspx>.

<sup>39</sup> Cited September 13, 2012 at

[http://mainecenterforelderlaw.com/lawyer/Kennebunk\\_York\\_ME/Medicaid\\_\(MaineCare\)\\_Planning\\_pa2953.htm](http://mainecenterforelderlaw.com/lawyer/Kennebunk_York_ME/Medicaid_(MaineCare)_Planning_pa2953.htm)

<sup>40</sup> Cited September 20, 2012 at

[http://massabesic.maineadulted.org/courses/course/planning\\_for\\_mainecare\\_eligibility](http://massabesic.maineadulted.org/courses/course/planning_for_mainecare_eligibility)

<sup>41</sup> Text of the “Medicaid Long-Term Care Reform Act (H.R. 6300)” may be found at <http://www.govtrack.us/congress/bills/112/hr6300/text>.

Medicaid, not just for institutional level of care;” and that the “Medicaid compliant annuity” and “half-a-loaf” self-improvement strategies should be ended.

Because of federal law, regulations and policy interpretations that permit Medicaid planning techniques to continue and as a result of PPACA’s maintenance of effort requirement, Maine cannot implement more restrictive eligibility policies to constrain the practice of Medicaid planning and prevent affluent individuals from capturing state revenues intended to help the poor.

### **MaineCare LTC Eligibility in Practice**

As explained above, basic Medicaid financial eligibility rules are generous in the first place, were expanded to their limits of generosity in some areas by earlier MaineCare policies, and are now locked in by the PPACA maintenance of effort requirements. Our interviews with program managers, eligibility workers and supervisors in the Augusta and Portland MaineCare offices revealed that the financial impact of these policies as implemented in practice is substantial.

#### **Holes in the Financial Eligibility Screen**

**Prepaid burial funds:** Between 80% and 90% of all MaineCare LTC applications have prepaid burial funds averaging \$7,000 to \$8,000 per case. Eligibility workers stated that they often recommend pre-paying burial expenses as a means for applicants to qualify for benefits sooner and to avoid paying privately for care. Across the caseload, the exemption of prepaid burial funds constitutes a very substantial transfer of wealth that would otherwise go for private LTC financing to offset families’ funeral expenses for their elders. It also amounts to a large subsidy of the funeral industry at the expense of MaineCare LTC expenditures for the indigent. Because federal law requires an unlimited exemption for prepaid burial expenses, Maine has no authority to restrict this practice.

#### **Asset shelters and divestments**

MaineCare eligibility workers concurred that approximately 40% of all MaineCare LTC applications involve some form or another of asset shelter or divestment besides the pervasively utilized prepaid burial exemption. Examples cited by the workers include:

- **Home equity exemption:** Half or more MaineCare LTC recipients own homes that are exempt as long as the recipient or the recipient’s personal representative indicates an intent of the recipient to return to the home. Intent is subjective and does not require verification that return to the home is medically possible. Given that the median value of owner-occupied housing in Maine is \$176,200<sup>42</sup> and MaineCare exempts up to \$750,000, it is unlikely that the home equity, even of relatively affluent

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<sup>42</sup> U.S. Census Bureau, “Maine Quick Facts” at <http://quickfacts.census.gov/qfd/states/23000.html>.

people, would be used to fund LTC privately in such a manner as to lower state and federal expenditures.

- **Household goods** are totally exempt under federal law, so eligibility workers explained they do not even ask about such property, which may include valuable art work, antiques or jewelry. Technically, items acquired or held because of their value or as investments, should be treated as countable assets, not household goods, but because eligibility staff do not ask about such belongings, this potentially substantial wealth escapes consideration.<sup>43</sup>
- **Annuities:** Approximately 15% of all MaineCare LTC cases involve annuities used to shelter sometimes “hundreds of thousands of dollars” immediately prior to the applicants’ qualifying for benefits. According to the workers: “Assets are transferred to the community spouse who creates an annuity and gets it all back within the actuarial life expectancy of the institutionalized spouse, sometimes in less than a year, with monthly incomes derived from the annuities of up to many thousands of dollars.”

*Example:* “Every other case, maybe 2/3 of the cases from attorneys, involve annuities. I recently had a case with an 83- and 84-year-old couple, who, by advice from their attorney, purchased an annuity for \$450,000 with a monthly pay out of \$17,000 to make the wife eligible for MaineCare and provide income for the husband in the community. We never look at their assets after they’re eligible. Once annuities are created, they get all the money back. One of the requirements is that the state gets any remainder. I’ve only had one client die where the state got any money back. It’s aggravating when you see this. They’re obviously over the spousal asset limit.”

- **Reverse half a loaf** is a technique used by singles if the annuity strategy is not available: “You apply; we do a look back and create a transfer of assets penalty; then you transfer half the money back and we have to forgive the remaining penalty. We hate it, they do it. A regular person who can’t afford an attorney does not know there is this way out.”
- **Inaccessible assets:** 5% or 10% of MaineCare LTC cases according to the workers involve property owned jointly with some other person who refuses to sell his or her share. Such property remains exempt for purposes of determining eligibility.
- **Asset transfers beyond the five-year look back:** Workers estimated that between 1% and 2% of MaineCare LTC applicants planned early enough

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<sup>43</sup> “Items that an individual acquires or holds because of their value or investment are not household goods, even if they otherwise meet the definition of household goods in SI 01130.430C.1.”

to transfer their wealth outside the five-year asset transfer look back period. Resources transferred outside that window are not counted no matter how large. In fact, applicants are not even asked about such transfers.

The inescapable conclusion one reaches after examining MaineCare LTC eligibility policies and practices is that just about anyone qualifies for the program's expensive LTC benefits without much problem, except, ironically, the poor, who often lose everything quickly for lack of professional financial and legal advice.

### **Working Conditions**

Eligibility workers in both MaineCare regional offices reported heavy LTC case workloads of up to 500 cases per worker. They explained that the eligibility rules they are charged with enforcing are so complicated that it takes two or three years to learn the job fully. Yet turnover is high and most of the workers had less than two years in their positions. Staff shortages and the need to double up to cover vacations and sick leaves exacerbate the problem. Workers complained that they receive no training even though LTC is more expensive and more complicated than other programs for which eligibility workers are trained extensively. With a 45-day limit to approve or deny initial applications, workers have little time for routine verifications and mandatory periodic case reviews, which consequently are not always done. They estimate that 40% to 50% of minor eligibility considerations and 20% of major issues such as asset transfers "fall through the cracks."

### **Application processing**

Nearly all MaineCare LTC applications are submitted by mail or fax. Very few face-to-face interviews occur now, making it harder, according to the workers, for them to discern potentially misleading or fraudulent information.

Approximately 20% of all LTC applications are actually completed and submitted by attorneys on behalf of applicants and their families. Workers spend a considerable amount of time answering questions from lawyers and family members about MaineCare eligibility rules. "Cases with an attorney involved amount to 35% of our cases, but account for 50% of our work." MaineCare planning lawyers do not come cheap: "The norm we see is \$10,000 to \$15,000 for attorney's fees to become eligible for benefits."

The workers made interesting observations about the effect of Maine's easy LTC eligibility and greater availability of assisted living slots than in other states (through the PNMI program). The state may have a serious problem with "welfare immigration."

- "Quite a few people return home to Maine because of the generosity of our eligibility rules. Why be limited to \$2,000 [in exempt assets] when you can hope to get your clutches on \$10,000?"

- “People live in New Hampshire but bring family members to a [bordering Maine] York county nursing home.”
- “We have one of the most available assisted living facility programs in the country. A woman applied for her mother in Connecticut where [Medicaid doesn’t cover] boarding homes, so then she applied here in Maine because she has relatives here.”

Another problem related to application processing, which the eligibility workers stressed, is that hospitals and nursing homes often advise people who cannot possibly qualify for Medicaid because of high income and/or assets to apply nevertheless so that the cost of the Goold medical assessment, which is required prior to institutionalization even for private payers, is diverted to the MaineCare program. MaineCare covers that expense whether or not the applicant is ultimately deemed eligible for benefits. This technique also avoids the seven or eight month wait for a Goold assessment that may occur otherwise.

In summary, workers stated:

- “Budgets are decreasing.”
- “We don’t have enough staff and we have an exploding elder population and increasing need for LTC services.”
- “We don’t feel like we’re capturing everything.”

Because Federal Medicaid Eligibility Quality Control (MEQC) does not review LTC cases, it is highly likely that these working conditions and application processing policies result in some cases being deemed eligible incorrectly.

### **The Impact on Long-Term Care Providers**

The fact that MaineCare LTC benefits are so easy for most people to obtain impacts LTC providers severely. Almost three-fourths of nursing home residents in Maine are covered by MaineCare. The figure is even higher for assisted living facility residents, 80% of whom MaineCare’s PNMI program covers.<sup>44</sup>

This high dependency on MaineCare is problematical because the program reimburses providers at such a low rate. MaineCare pays nursing homes \$189 per day, or only 69% of the \$275 per day private-pay rate. The MaineCare rate for assisted living (PNMI) is only half of the private rate: a little less than \$100 compared to the \$200 per day private payers are charged. One study found that MaineCare reimburses nursing facilities \$21.21 per bed day less than allowable costs, literally less than the cost of providing the care.<sup>45</sup>

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<sup>44</sup> These percentages are based on interviews with long-term care providers listed in the Appendix.

<sup>45</sup> “A Report on Shortfalls in Medicaid Funding for Nursing Home Care,” ELJAY, LLC for The American Health Care Association, December 2011, p. 7;

Low MaineCare LTC rates and the higher Medicare and private-pay rates required for balance all create problems. With most of their residents paying less than the cost of the care, LTC providers have difficulty paying caregivers enough to ensure an adequate supply of highly-qualified nurses and aides. Relatively generous Medicare reimbursements that have helped balance low Medicaid LTC reimbursements in the past are becoming more and more dubious as pressures mount to reduce that program's costs. The much higher rates charged to private payers increase the incentive families have to shelter or divest assets in order to qualify for MaineCare thus further eroding private-pay census and increasing the number of MaineCare residents. It has become a vicious downward cycle.

Some LTC facilities have closed already due to high MaineCare occupancy and low reimbursements. Others have cut back on the number of available MaineCare slots. More are likely to follow suit in the absence of increased MaineCare reimbursement rates in the future. One provider told us: "We probably lose \$250,000 to \$350,000 per year covering 50 Medicaid residents. Our ten residents on Medicare balance the Medicaid losses, but we're still trying to rebound from the Medicare rate reduction last October." Further Medicare cuts are anticipated and Medicare occupancy is declining as well, now down to only 10% statewide. Unless new sources of private financing are found to supplement LTC provider revenues, further deterioration of MaineCare access and quality are likely to ensue.

### **Private Financing Alternatives**

What are the private LTC financing alternatives that might help improve LTC provider revenues in Maine and reduce the financial pressure on MaineCare and state taxpayers? There are really only four possibilities.

1. **Personal Assets:** As explained above, federal Medicaid asset eligibility rules, as expanded nearly to their limits of generosity by MaineCare, do not compel people to spend down their wealth significantly in order to qualify for LTC benefits. Individuals may pay for their own LTC out of ignorance or because of a sense of personal responsibility, but most Mainers qualify easily without fancy legal strategies or significant spend down and wealthier citizens may qualify by seeking the professional assistance of MaineCare planners. The maintenance of effort rule prevents Maine even from constricting LTC financial eligibility to limits that federal law would otherwise allow in the absence of the MOE. Thus, as long as the MOE rule maintains MaineCare LTC financial eligibility at current generous levels, it is unlikely that more private wealth will flow into the LTC service delivery system to relieve the financial pressure on public resources.

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[http://www.ahcanal.org/News/news\\_releases/Pages/MedicaidFundingGapWidensforNursingFacilities.asp](http://www.ahcanal.org/News/news_releases/Pages/MedicaidFundingGapWidensforNursingFacilities.asp)  
x.

2. **Estate Recovery:** Federal law requires all states to recover the cost of care provided by Medicaid from the estates of deceased recipients.<sup>46</sup> The purpose of this requirement is to restore funds previously sheltered from spend down, especially resources sheltered by means of the home equity exemption, so they are available to help others in need rather than passing as a “windfall”<sup>47</sup> to heirs.<sup>48</sup>

MaineCare has a relatively successful estate recovery program. Average recoveries for state fiscal years (SFY) 2009-2012 were \$6,725,000 per year. Staff estimate the cost of recovery, including four positions, benefits and other expenses, to be \$272,673 per year for a return on investment (ROI) of approximately 25 to one. MaineCare estate recovery staff anticipate that with stronger laws supporting recovery and with additional staff, annual recoveries could realistically increase by \$1.5 million to \$2.0 million.

Potential additional revenue from estate recoveries may be even higher, however. Maine’s program exempts the first \$7,000 of estate value from recovery; does not recover from the estates of spouses predeceased by MaineCare recipients;<sup>49</sup> and does not use TEFRA liens<sup>50</sup> to ensure that real property is retained by recipients until recovery from their estates.

A small, informal sample of new estate recovery cases showed that seven out of ten owned homes meaning potential recoveries should be substantial.<sup>51</sup> Yet, of MaineCare’s 4217 nursing facility recipients, only 297 or 7.1% own homes that are exempt due to “intent to return.”<sup>52</sup> These homes have an average equity value

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<sup>46</sup> The Omnibus Budget Reconciliation Act of 1993 made estate recovery mandatory.

<sup>47</sup> “It is their children, after all, who stand to inherit whatever property remains after the costs of long-term care are paid and who currently reap the windfall of Medicaid subsidies. We must emphasize that the issue is enrichment of nonneedy adult heirs, not denial of care to the elderly.” (Office of Inspector General, US Department of Health and Human Services, “Medicaid Estate Recoveries: National Program Inspection,” June 1988, pps. 47-48; <https://oig.hhs.gov/oei/reports/oi-09-86-00078.pdf>.)

<sup>48</sup> Congress made it clear 30 years ago that “all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children will be used to defray the cost of supporting the individual in the institution.” (Source: *United States Code, Congressional and Administrative News, 97th Congress—Second Session—1982, Legislative History (Public Laws 97-146 to 97-248)*, vol. 2 (St. Paul, MN.: West Publishing), p. 814, cited in 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 Treatment of the Home: Determining Eligibility and Repayment for Long-Term Care,” Policy Brief no. 2, April 2005, p. 10.)

<sup>49</sup> The General Accounting Office (now called the Government Accountability Office) found in a 1989 study that “In the eight states studied, as much as two-thirds of the amount spent for nursing home care for Medicaid recipients who owned a home could be recovered from their estates or the estates of their spouses.” (General Accounting Office, “Recoveries from Nursing Home Residents’ Estates Could Offset Program Costs,” HRD-89-56, March 7, 1989, p. 3; <http://www.gao.gov/assets/150/147459.pdf>.)

<sup>50</sup> The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA ’82) authorized states to place liens on homes owned by institutionalized Medicaid recipients to ensure their availability for later estate recovery so long as no surviving exempt dependent relative lives in the property.

<sup>51</sup> Source: Email, October 24, 2012, from Deen Dunn, Manager, State of Maine Estate Recovery: “We did look at a small ample and there were 7 out of 10 cases that had homes at the time we processed.”

<sup>52</sup> As of 2010, Maine had 6390 nursing home residents, 66% of whom or 4217 relied primarily on MaineCare. (Source: StateHealthFacts.org,

of \$105,114 and a median equity value of \$87,200, both far below MaineCare's \$750,000 home equity exemption. Because we know a much larger percentage of age-65-plus people own homes, a key question to answer is "what happened to that home equity before the homeowners ended up on MaineCare?"

By hiring more staff, seeking stronger legislative authorities, researching and applying best practices from other states, Maine could aspire to achieve estate recoveries comparable to those of the most successful state, Oregon, which brought in recoveries equal to 5.8% of its Medicaid nursing home expenditures.<sup>53</sup> A comparable rate of recovery for Maine would more than double the non-tax revenue Maine recovers from estates to \$13.8 million per year.<sup>54</sup>

- 3. Home Equity Conversion:** Maine's home ownership rate of 73.1% is much higher than the national average of 66.6%. The median home value in the state is \$176,200,<sup>55</sup> which is only 23.5% of MaineCare's \$750,000 home equity exemption. Older people are more likely to own homes (80% nationally) and to own them free and clear (65%).<sup>56</sup> Eligibility workers estimated that over half of MaineCare LTC recipients still own homes, the value of which may not be recovered from estates because MaineCare estate recovery does not use TEFRA liens to secure the property nor pursue spousal recoveries and estate recovery is relatively easy to avoid with the help of professional MaineCare planners. For the most part, home equity goes unused to fund LTC in Maine.

Reverse mortgages are highly regulated financial products that enable homeowners 62 years of age and older to tap the equity in their homes without monthly payments in order to supplement their incomes. New "Saver Reverse Mortgages" have significantly reduced the up front closing costs on these products per dollar of available equity. Informal arrangements within families can achieve the same purpose by means of the younger generation supplementing the older generation's income in exchange for a gradual transfer of the parents' home equity to the adult children. Based on our research and interviews, neither formal nor informal reverse mortgages are used very widely to fund LTC, not for care in the home nor in facilities.

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<http://www.statehealthfacts.org/profileind.jsp?cat=8&sub=97&rgn=21>) but currently only 297 cases or 7.1% have homes with values over \$1 exempted due to intent to return according to an October 27, 2012 email from Reinhold Bansmer, Special Projects Program Manager, DHHS, Augusta.

<sup>53</sup> 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>.

<sup>54</sup> MaineCare spent \$237 million on nursing facilities in 2010. (Source: StateHealthFacts.org, <http://www.statehealthfacts.org/profileind.jsp?ind=180&cat=4&rgn=21>.) At a 5.8% rate of recovery, matching Oregon's, Maine would recover \$13.8 million.

<sup>55</sup> U.S. Census Bureau, "Maine Quick Facts" at <http://quickfacts.census.gov/qfd/states/23000.html>.

<sup>56</sup> U.S. Census Bureau, Current Housing Reports, Series H150/09, *American Housing Survey for the United States: 2009*, U.S. Government Printing Office, Washington, DC, 20401. Printed in 2011. Table 2-1. Introductory Characteristics—Occupied Units, p. 11 and Table 3-15. Mortgage Characteristics—Owner-Occupied Units, p. 65; <http://www.census.gov/prod/2011pubs/h150-09.pdf>.

If it were not for federal Medicaid's minimum \$525,000 home equity exemption as enhanced to \$750,000 by MaineCare and locked in by the PPACA maintenance of effort rule, the enormous wealth held in real property could be utilized to fund quality LTC for Mainers and to relieve the financial pressures on MaineCare and taxpayers.

4. **Long-Term Care Insurance:** LTC insurance (LTCI) is a financial product that enables policy holders to leverage relatively inexpensive annual premiums against a significant risk of catastrophically expensive LTC costs. Interviewees for this study said LTCI sales in Maine are flat to declining. Although a relatively high 11.4%<sup>57</sup> of Mainers age 45 and older<sup>58</sup> already own the product, LTCI remains a niche market for several reasons.

Common explanations for LTCI's languishing market include the product's perceived high cost and consumers' "denial," the attitude that "it won't happen to me." LTCI premiums seem high because, compared to fire insurance, the risk and cost of the insurable event occurring are much higher. Interviewees told us, however, that high quality LTCI coverage is readily available in the workplace for \$20 to \$40 per pay period. Hybrid products combining LTC protection with life insurance or annuities, which consumers may need and purchase anyway, are another affordable means to cover the LTC risk.

Denial is probably the greater cause of consumer indifference to LTC insurance protection. One must ask, however: "If the risk and cost is so great, why don't people worry about it enough to seek private insurance protection?" The answer in Maine and elsewhere is fairly obvious. Consumers can ignore the risk and cost of LTC, avoid the premiums for private coverage, and qualify for publicly financed MaineCare after the insurable event occurs without significant asset spend down and, with careful planning, avoiding estate recovery.

Maine's LTC Partnership program, which forgives MaineCare spend down requirements up to the amount of private insurance protection purchased and used, has helped, but only on the margin because spend down is so easy to avoid anyway and most consumers do not worry about LTC until they already need care at which time it is too late to purchase a Partnership or any other LTC insurance policy.

Once again, this situation is the result of generous federal Medicaid LTC financial eligibility rules, MaineCare's more generous application of those rules, and the maintenance of effort rules lock in of existing policies.

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<sup>57</sup> In Maine, 71,156 LTCI policies were in force at the end of 2011 according to Jesse Slome, "The 2012-2013 Sourcebook for Long-Term Care Insurance Information," American Association for Long-Term Care Insurance, 2012, p. 14.

<sup>58</sup> Maine has 499,185 age 45 plus. (Source: Infoplease, Demographic Statistics Maine, <http://www.infoplease.com/us/census/data/maine/demographic.html>.)

## Conclusion

MaineCare's LTC financing crisis stems from the state's having provided easy access to government financed care for decades. Mainers have been desensitized to the high risk and cost of LTC. Most of them do not plan ahead for LTC, do not insure for the risk, and do not use personal resources including home equity to fund LTC. This situation is unlikely to improve and is highly likely to deteriorate unless or until MaineCare tightens LTC eligibility enough to target the program's scarce resources to the truly needy.

Saving MaineCare for the poor, who are its originally intended clientele, will not only save money immediately, it will enable the state to sustain and improve other priorities. Furthermore, when it becomes clear to middle-class and affluent citizens that LTC is a personal financial responsibility, more of them will plan responsibly for LTC, avoid MaineCare dependency, and reduce financial pressure on the program further. Maine could aspire to eliminate wait lists for key programs and pay LTC providers sufficiently to ensure high-quality, professional caregivers.

Our interviews with MaineCare managers and staff revealed clearly that they are aware of the ways in which the program has been co-opted by the non-poor. Several factors prevent them, however, from taking corrective action. Most importantly, federal law and regulations require extremely generous LTC eligibility policies. Furthermore, the maintenance of effort requirements in ObamaCare forbid the state to tighten even to the extent that was allowed before the MOE took effect. Another important inhibiting factor is the political headwind created by the mistaken, but widely held public opinion that any reduction in access to MaineCare hurts the poor. In fact, eliminating access to MaineCare LTC benefits for people who can pay their own way benefits the poor by reducing the number of people competing for the program's limited resources.

Recognizing the severe federally imposed limitations on MaineCare's ability to operate a high-quality, cost-effective LTC program for the needy, we recommend the following actions and considerations.

## Recommendations

1. **Enhance MaineCare's estate recovery program**, which MOE does not constrain, by reducing the \$7,000 exemption from recovery, pursuing spousal recoveries, imposing TEFRA liens on eligible properties, researching and implementing best practices from other states and hiring more staff to produce a potential extra savings roughly equal to the program's current average annual recoveries of \$6.7 million.
2. **Continue to seek redress of the maintenance of effort requirement** from the federal government. In the absence of MOE, Maine could tighten LTC eligibility within existing federal rules in order to preserve benefits for the most needy by (a) replacing the "medically needy" income standard with a marginally more restrictive "income cap," (b) reducing the home equity exemption from \$750,000

to the federal minimum of \$525,000,<sup>59</sup> (c) substituting the current spousal asset protection of \$113,640 with “half the joint assets not to exceed \$113,640” as allowed by federal law.

3. **Review a valid random sample of MaineCare LTC eligibility cases** to establish more precisely how much state and federal money is diverted from providing services to the poor to subsidizing the LTC expenses of more prosperous people due to the generous and elastic eligibility policies identified in this study. Use these findings to support the state’s case for exemption from the MOE rule and to justify exemption from overly generous federal eligibility rules.
4. **Seek an “1115” waiver<sup>60</sup> to experiment with eligibility limits** that are otherwise not permitted by federal law, but which would ensure that MaineCare benefits go to those most in need and do not discourage others from planning to stay off MaineCare when they need LTC. Such an experiment could include (a) prohibiting the use of Medicaid-compliant annuities to divert unlimited assets from spend down liability instantaneously, (b) requiring the spend down of all or most home equity, through sale of the property or by means of a reverse mortgage, before MaineCare eligibility is granted, (c) ending the reverse half-a-loaf MaineCare planning strategy, (d) expanding the look back period for uncompensated asset transfers done to qualify for MaineCare from five years to ten years as in Germany’s LTC social insurance program, and (e) implementing any number of other restrictions designed to protect MaineCare for the needy while requiring people of means to pay privately for LTC and thus encouraging future generations to prepare for LTC while they are still young enough, healthy enough and affluent enough to do so.
5. **Initiate a major public awareness campaign** to educate the public that fiscal constraints on MaineCare’s LTC program make it impossible to provide benefits as widely in the future as in the past so that over time (a) MaineCare LTC eligibility will be limited of necessity to the very poor, (b) people with personal resources, including home equity, will need to pay for their own LTC, (c) much stronger estate recovery requirements will apply, and (d) families should plan early by means of saving, investment, insurance or home equity conversion to pay privately for LTC. The campaign should emphasize that MaineCare’s goal is not only to save money but to improve services for the poor, eliminate waiting lists for the MR/DD program, prevent bed caps and service cuts, and compensate caregivers adequately to ensure their quality and availability.

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<sup>59</sup> By comparison, England’s socialized health care system allows only a \$36,000 asset exemption, including home equity.

<sup>60</sup> “About Section 1115 Demonstrations: Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give States additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- \* Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible
- \* Providing services not typically covered by Medicaid
- \* Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.”

(Source: Medicaid.gov, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html>, cited October 31, 2012.)

**Appendix: List of Interviewees**

Reinhold “Ron” Bansmer, Special Projects Program Manager, DHHS, Augusta

Ruthann Bisbee, LTC Eligibility Specialist, DHHS/OFI, Augusta

Ken Bowden, CEO, First Atlantic HC, South Portland

Linda A. Boynton, Eligibility Specialist, DHHS LTC, Portland

Thomas Buchanan, Eligibility Specialist, DHHS LTC, Portland

Amy Catling, Owner, Seacoast Family Mortgage, York, ME

Valerie E. Coleman, Regional Vice President of Operations, Genesis HealthCare, Portland

Jack Comart, Esq., Litigation Director, Maine Equal Justice Partners, Augusta

Phil Cyr, Administrator, Caribou Rehab and Nursing, Caribou, ME

Jessica Drenning, Eligibility Specialist, DHHS LTC, Portland

Deen Dunn, Manager, State of Maine Estate Recovery, Augusta

Steve Eastman, Reverse Mortgage Consultant, Security One Lending, Raymond, ME

Norman Farrington, LTC Eligibility Specialist, DHHS/OFI, Augusta

Tony Forgione, C.E.O., Seventy-Five State Street, Portland

Karen D. Foster, State Representative, Augusta

Thomas Foster, Insurance Agent, Augusta

Brenda Gallant, R.N., Executive Director, the Maine Long-Term Care Ombudsman Program, Augusta

Dennis Gaudette, St. Mary’s Health System, Lewiston, ME

Marion Golden, Eligibility Specialist, DHHS, Portland

Todd Grove, Long-Term Care Financial Partners, Portland

Laura L. Hall, LTC Eligibility Specialist, DHHS/OFI, Augusta

Terry Hamilton, OFI Program Administrator, DHHS-OFI, Portland

Bethany L. Hamm, Division Director for Policy and Programs, DHHS, Augusta

Carroll Harper, LTC Specialist, Southwest Harbor, ME

Ana Hicks, Senior Policy Analyst, Maine Equal Justice Partners, Augusta

Joshua Hinds, LTC Eligibility Specialist, DHHS/OFI, Augusta

Natasha Hoffman, Customer Representative, DHHS LTC, Portland

Adam Hooper, LTC Supervisor, DHHS/OFI, Augusta

Kelley A. Hooper, LTC Eligibility Specialist, DHHS/OFI, Augusta

Marti Hooper, Life and Health Actuary, Bureau of Insurance, Augusta

Arthur Hosford, Attorney, Bureau of Insurance, Augusta

Sherry Ingalls, Senior Insurance Rate Analyst, Bureau of Insurance, August

Pauline Kibbin, LTC Eligibility Specialist, DHHS/OFI, Augusta

Oleg Kladov, Eligibility Specialist, DHHS LTC, Portland

Lindsay Laxon, Consumer Outreach Specialist, Bureau of Insurance, Augusta

Tatsiana S. Mitchell, Eligibility Specialist, DHHS LTC, Portland

Stefanie Nadeau, MaineCare Director, DHHS, Augusta

Craig H. Nelson, Doyle & Nelson, Attorneys at Law, representing Leading Age, formerly the American Association of Homes and Services for the Aging, Augusta

Kerry Peabody, LTC Specialist, Portland

Teresa Potter, Reimbursement Specialist, State of Maine Estate Recovery, Augusta

Kathy Reynolds, LTC Eligibility Specialist, DHHS/OFI, Augusta

Mary Jane Richards, COO, North Country Associates, Lewiston, ME

Michael Roberts, LTC Form Reviewer and Complaint Examiner, Bureau of Insurance, Portland

Timothy Schott, Deputy Superintendent, Bureau of Insurance, Augusta

Karen Spearin, Eligibility Specialist, DHHS LTC, Portland

Susan St. Michel, LTC Supervisor, DHHS/OFI, Portland

Bob St. Pierre, C.F.O., Maine Veterans Homes, Augusta

Pamela Stutch, Attorney, Bureau of Insurance, Augusta

Cindy Thomas, LTC Eligibility Specialist, DHHS/OFI, Augusta

Raymond E. Veroneau, Jr., CLTC, Veroneau Insurance, Scarborough, ME

Neil Wyrick, Eligibility Specialist, DHHS LTC, Portland

