
Medicaid Estate Planning and Estate Recovery in Ohio



August, 1999

*Prepared for
Governor Bob Taft,
Speaker of the House of Representatives
Jo Ann Davidson, and
President of the Senate
Richard H. Finan*

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Roster of Study Group Members

Eileen Banning, Supervisor, Nursing Home Unit, Franklin County Department of Human Services, 80 East Fulton Street, Columbus, Ohio 43215-5127

Kay Boettcher, Facility Contracting Section, Ohio Department of Human Services, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Robert Byrne, Assistant Attorney General, Attorney General's Office, Revenue Recovery Unit, 101 East Town Street, 2nd Floor, Columbus, Ohio 43215-5148

Christopher Carlson, Legal Services Section, Ohio Department of Human Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423

Roster of Study Group Members

Mike Compton, Association of Ohio Philanthropic Homes, Housing and Services for the Aged, 855 South Wall Street, Columbus, Ohio 43206

Bob Frankart, Legal Services Section, Ohio Department of Human Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423

Greg Finnerty, Office of Government Affairs, Ohio State Bar Association, 88 East Broad Street, Suite 870, Columbus, Ohio 43215

Tom Gilbride, Legal Services Section, Ohio Department of Human Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423

Brenda Graf, Executive Director, Ohio Academy of Nursing Homes, 50 West Broad Street, Suite 1801, Columbus, Ohio 43215

Kim Irwin, Chief, Facility Contracting Section, Ohio Department of Human Services, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Kim Kivimaki, Office of State Representative Joan Lawrence, 77 South High Street Columbus, Ohio 43266-0603

Beverley Laubert, State Ombudsman, Elder Rights Program, Ohio Department of Aging, 50 West Broad Street, 9th Floor, Columbus, Ohio 43215-5928

Mary Leonard, Office of State Senator Roy Ray, Statehouse, Columbus, Ohio 43215

Barbara Michael, Columbus Bar Association Probate Court Committee, Ohio State Bar Association Law Elder Committee, 155 West Main Street, Suite 100 B, Columbus, Ohio 43215

Nancy Rickson, College Intern, Section of Facility Contracting, Bureau of Long Term Care Facilities, Ohio Department of Human Services, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Jim Rosmarin, Ohio Department on Aging, 50 West Broad Street, 9th Floor, Columbus, Ohio 43215-5928

Nancy Savage, Member At Large, Lockbourne, Ohio 43137. Retired supervisor of Nursing Home Unit, Franklin County Department of Human Services, 80 East Fulton Street, Columbus, Ohio 43215-5127

Harry Saxe, Chief, Bureau of Long Term Care Facilities, Ohio Department of Human Services, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Ann Shane, Bureau of Consumer and Program Support, Ohio Department of Human Services, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Marty Sweterlitsch, Attorney at Law, Baker, Baker & Sweterlitsch, 50 West Broad Street, Suite 1326, Columbus, Ohio 43215

Karen Toohey, Medical Assistance Coordinator, Ohio Department of Human Services, Canton District Office, 101 Cleveland Avenue North, Suite 200, Canton, Ohio 44702-1701

Peter Van Runkle, Director of Legal Services, Ohio Health Care Association, 55 Green Meadows South, Westerville, Ohio 43081

Karen Visocan, 476 ½ South Main Street, Mansfield, Ohio 44907

Lynne Weibl, Legal Services Section, Ohio Department of Human Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423

Mike Wood, Franklin County Department of Human Services, 80 East Fulton Street, Columbus, Ohio 43215-5127

Theresa Woodward, Office of Legislation, Ohio Department of Human Services, 30 East Broad Street, 31st Floor, Columbus, Ohio 43266-0423

Chuck Zalac, Policy Unit, Bureau of Community Services, Ohio Department of Human Services, 30 East Broad Street, 27th Floor, Columbus, Ohio 43266-0423

David Zwyer, Developmental Disabilities Planning Council, Ohio Department of Mental Retardation and Developmental Disabilities, 30 East Broad Street, 12th floor, Columbus, Ohio 43266-0415

Prepared by Kim N. Irwin, M.S.W., M.A.
Bureau of Long Term Care Facilities
Office of Medicaid
Ohio Department of Human Services
30 East Broad Street, 33rd Floor
Columbus, Ohio 43266-0423
614-466-9243

Table of Contents

Acknowledgments	–
Roster of Study Group Members	--
Executive Summary	-i-
Legislative Request	-i-
Chapter 1: Introduction	-ii-
Chapter 2: Study Methodology	-iii-
Chapter 3: Performance of Ohio’s Current Medicaid Estate Recovery Program	-iii-
Chapter 4: Design Issues of State Medicaid Estate Recovery Programs	-iv-
Chapter 5: Use of Liens to Enhance Recovery Efforts	-iv-
Chapter 6: Key Concepts of Basic Medicaid Eligibility for the Aged- Blind-Disabled (ABD) Population	-iv-
Chapter 7: Key Concepts of Medicaid Eligibility for Persons Cared for in Long Term Care Facilities or Enrolled on Waiver Home Care Programs	-v-
Chapter 8: “Striking It Poor”: Policies Regarding the Transfer of Assets Prior to Medicaid Application	-v-
Chapter 9: Medicaid Estate Planning and Divestiture of Assets	-v-
Chapter 10: Results from Studies of County Medicaid Eligibility Workers in Ohio	-vi-
Chapter 11: Observations and Summary	-vii-
Chapter 1: Introduction	-1-
Statement of the Purpose of this Report	-1-
Long Term Care Overview and Trends	-2-
Medicaid Has Evolved into the Primary Payer for Long Term Care	-2-
Many People Using Medicaid for Long Term Care Were Not Always, or Are Not Poor	-3-
Delivery of LTC Services	-3-
Current Distribution of Financing of Long Term Care	-4-
Current Cost Containment Strategies	-4-
Long Term Care Insurance	-5-
Policy Ambiguity: the Private and Public Responsibilities for Long Term Care	-6-
Chapter 2: Study Methodology	-9-
Surveyed Literature and Internet	-9-
Canvassed County Eligibility Workers	-9-
Collected Estate Recovery Program Information from Other States	-10-
Studied Ohio’s Estate Recovery Program Operations	-10-
Convened Study Group	-10-

Chapter 3: Performance of Ohio’s Current Medicaid Estate Recovery Program -11-

OBRA 1993: Federal Mandate -11-
 Effective Date of New Provision -11-
 Implementation in Ohio -11-
Designation of Attorney General’s Office -12-
Cost Benefit Analysis: Recovery Ratio to Labor Cost of ODHS/AGO -13-
Ohio Estate Recovery Collections Have Increased Every Year Since the Program
 Began -14-
Funds Collected Are Returned to Federal and State Treasuries -14-
Ohio’s Estate Recovery Program Helps to Defray Future Medicaid Long Term
 Care Costs -14-
Ohio’s Low Collection Rate in Comparison to Other States -18-
Comparison to Other States That Contract out Recovery Efforts -18-
Collection Rates -18-
Contract Fees -19-
Factors in Ohio That May Be Preventing a Higher Rate of Recovery -19-
Ohio’s Program Design Meets Only Minimum Federal Requirements -19-
Ohio Has Not Implemented Certain Authorized Features of the Program -19-
Ohio Requires Disposition of Real Estate Assets Prior to Death -20-

Chapter 4: Design Issues of State Medicaid Estate Recovery Programs -21-

U.S. Dept. of HHS: HCFA Instructions to States -21-
Study Results from Other States or on National Level -21-
Target Populations: Which Medicaid Participants Must Be Included in the Estate
 Recovery Program? -22-
 First Category: Permanently Institutionalized Individuals -22-
 What is the Scope of Recovery for Permanently Institutionalized
 Individuals? -23-
 Does the Category “Permanently Institutionalized” Include Children? -24-
 Second Category: Individuals Age 55 or Older -25-
 What is the Scope of Recovery for Persons Age 55 and Older? -25-
 What Are the Differences in the Scope of Recovery Between the Two
 Target Groups? -26-
 Third Category: Individuals with Long Term Care Insurance Policies Used for
 Medicaid Eligibility “Disregards” -26-
 What is a “Partnership State?” -27-
 Ohio is NOT a Partnership State -27-
Are There Any Limitations on Adjustment or Recovery? -28-
Limits on Recovery from Surviving Spouses, Minor Children, and Blind and Disabled
 Children -28-
Limiting Extent of Claim on Estate of Non-recipient -29-

How does the Estate Recovery Program Define Estate? What is the Scope of Recovery?	-30-
Does Ohio Seek Recovery If No Estate Is Filed with Probate Court?	-31-
What is the Role of Recovery of Personal Needs Allowance (PNA) Account Funds Managed by Nursing Facilities?	-31-
What About Recovery of Assets That Fall Outside the Probated Estate?	-32-
State Practice Surveys: Expansion of Definition of Estate	-32-
State Practice Surveys: Expansion to Jointly Owned Property	-33-
State Practice Surveys: Expansion to Life Estates	-33-
Issues Regarding an Expanded Definition of Estate	-33-
ORC 5111.181: Exclusion of Value of Life Insurance Policy in Determining Eligibility	-35-
Tracking Recovery by Asset Source	-35-
Can Recovery Be Waived Due to Undue Hardship?	-36-
Ohio's Undue Hardship Waiver	-37-
Other States' Undue Hardship Criteria	-38-
Is Recovery Prohibited If the Resource or Income Was Exempt for Eligibility Purposes?	-38-
What if Adjustment or Recovery is Not Cost Effective?	-39-
Does the State Provide Notice to Individuals About Medicaid Estate Recovery? ...	-41-
Notice at Time of Application for Medicaid Benefits	-41-
Notice to Individuals Affected by Recovery	-41-
What are the Tracking and Collection Procedures in Ohio?	-41-
Identifying Deaths and Claims Amounts	-42-
Tracking, Preserving and Recovering Assets	-43-
Do Other States Have Additional Methods That Enhance Recovery Efforts?	-44-
Recovery from Exempt Prepaid Burial Accounts	-44-
A Note about Ohio Burial Plans	-44-
Requirement for Executor to Provide Notice of Filing of the Estate to Estate Recovery Program	-45-
Elimination of the Statute of Limitations for Collection	-46-
Recovery of Small Amounts Directly from Bank Accounts When No Estate Is Filed	-46-
Moving Medicaid Estate Recovery Up on the List of Claim Priority	-47-
Making Certain Transfers Recoverable	-48-
Chapter 5: Use of Liens To Enhance Recovery Efforts	-51-
May Liens be Placed While the Medicaid Consumer is Still Alive? Is There More Than One Type of Lien Allowable in Medicaid Estate Recovery?	-52-
TEFRA Liens Are the Only Type of Lien Allowed to Be Placed Prior to Death of Recipient	-52-
TEFRA Liens Are Only Applicable to the Permanently Institutionalized Individual ..	-52-
Are There Any Restrictions That Prohibit Placement of TEFRA Liens?	-53-
When Must TEFRA Liens Be Dissolved /Terminated?	-53-

What About Liens Placed After the Death of the Medicaid Consumer? Post-death Liens (Non-TEFRA, Estate Liens)	-53-
Are There Limitations on Recovery Using Pre-death TEFRA and Post-death Non-TEFRA Liens?	-54-
Are There Restrictions on Placement of Non-TEFRA or Post-death Liens After Recipient’s Death?	-54-
Observations about Ohio Policy on Homestead Property and the Use of Liens	-54-
What Homestead Property Has Been Available for Recovery in Ohio?	-57-
Can Liens Be Applied to Persons Enrolled on Home Care Waivers?	-57-
What About Liens When There Is Joint Tenancy?	-59-
Are Liens a Useful Tool in Tracking Assets?	-59-
Widespread Misinformation is a Problem	-59-

Chapter 6: Key Concepts of Basic Medicaid Eligibility for the Aged-Blind-Disabled (ABD) Population -61-

Health Finance Literacy about Long Term Care Services and Financing	-61-
Introduction to Basic Medicaid	-62-
How is Aged, Blind, or Disabled Defined?	-63-
What are Citizenship Requirements?	-63-
Are There State Residency Requirements?	-63-
Does One’s Living Arrangement Matter?	-64-
Are There Additional Eligibility Requirements?	-64-
What Limits Are Placed on Resources / Assets?	-64-
Countable Resources	-64-
Exempt Resources	-65-
What Limits Are Placed on Income?	-65-
How is Financial Information That is Reported on Applications Verified?	-66-
Are There Problems with the IEVS Validation Process?	-67-

Chapter 7: Key Concepts of Medicaid Eligibility for Persons Cared for in Long Term Care Facilities or Enrolled on Waiver Home Care Programs -69-

Are Resource Requirements Different for Persons Needing LTC?	-69-
Are There Additional Eligibility Requirements for Users of LTC Services?	-70-
Eligibility for Singles	-71-
Eligibility for Couples: Spousal Impoverishment	-71-
What Is a Resource Assessment?	-72-
Who Is Entitled to a Resource Assessment?	-72-
What If the Couple Has Been Separated?	-72-
Does Property from a Prior Marriage or Inheritance Count?	-72-
What Resources Must be Considered? Are Exempt Resources Included in the Pooling of the Spouses’ Resources at the Time of Institutionalization?	-72-

How Are the Resources Split? How Are the Resources of the Community Spouse Protected?	-73-
What Happens If All of the Resources Are in the Community Spouse's Name?	-73-
What Are the Income Protections for the Community Spouse?	-74-
What Are Exceptional Circumstances That Would Increase the MMMNA?	-75-
Is A “Resource Assessment” the Same as a Determination of Resources at the Time of Application for Medicaid?	-75-
Medicaid Eligibility When One Spouse Enters a LTCF or Enrolls on an HCBS Waiver	-76-
The Spouse at Home (also known as the “Community Spouse”) Is Allowed To: The Spouse Entering Nursing Home or Enrolling on HCBS Waiver (also known as the “Institutionalized Spouse”) Is Allowed To:	-76-
Does Ohio Apply Income-First or Resource-First Methods to Determine Eligibility If There is a Community Spouse?	-76-
When Is the Home Treated as a Countable Asset?	-77-
How is Homestead Property Defined?	-77-
Can Homestead Property be Transferred?	-78-
When Is It No Longer Considered Homestead Property?	-78-
But, What If People Are Still Living There?	-78-
How Does This Differ from Transferring Homestead Property?	-79-
How does Medicaid Treat Income After Eligibility Has Been Established? (Post-Eligibility Treatment of Income)	-80-
How does Medicaid Treat Income That Arrives in “Lump Sums”?	-80-
Once on Medicaid, Is an Individual Allowed to Keep Any Allowances for Personal or Family Expenses?	-80-
What is the Individual’s Share of Costs for LTC Services? (Patient Liability Budgets)	-81-

Chapter 8: “Striking It Poor” --Policies Regarding the Transfer of Assets Prior to Medicaid Application **-83-**

How Does Medicaid Treat Transfers of Assets for Less Than Fair Market Value?	-84-
What Is an Improper Transfer?	-84-
To Whom Do the Improper Transfer Provisions Apply?	-84-
What Is an Asset?	-84-
What Is Fair Market Value?	-85-
What about Transactions Involving Jointly Owned Assets?	-85-
How Far Back In Time Does Medicaid Look for Improper Transfers? (The Look-back Period)	-86-
How Does an Individual Rebut the Presumption of an Improper Transfer? ..	-87-
Is There an Exception to the Improper Transfer Rule?	-87-
What Does “For the Sole Benefit Of” Mean?	-87-
How Is a Period of Restricted Eligibility Determined?	-88-

What If It Was a Stream (Source) of Income That Was Transferred?	-89-
What If the Person Is Already in the Nursing Home and Doesn't Pay For Care During the Period of Restricted Eligibility?	-89-
What Are Some Common Types of Asset Transfers?	-91-
Land Contracts and Mortgages	-91-
Definition	-91-
How is the Value of Property Agreements Determined?	-91-
Life Estates	-92-
Definition	-92-
How is the Value of the Life Estate Determined?	-92-
Has There Been an Improper Transfer?	-92-
Trusts	-93-
Two Types of Trusts Must Be Considered	-94-
Application of Trust Provisions	-94-
Medicaid Qualifying Trusts	-94-
Trusts Established on or after August 11, 1993	-95-
Revocable Trusts	-96-
Irrevocable Trusts	-96-
Exceptions to the Trust Policy	-97-
Special Needs Trusts (or Disability Trusts)	-97-
Pooled Trusts	-98-
Qualifying Income Trusts (QIT) (also known as "Miller-type" Trusts)	-99-
Supplemental Services Trusts	-99-
A Note about Trusts in New York	-100-
Annuities	-101-
Definition	-101-
Example:	-101-
A Note about Annuities in Oregon	-102-
Chapter 9: Medicaid Estate Planning and Divestiture of Assets	-103-
The Theory of Social Dilemmas: The Tragedy of the Commons	-104-
History of Attempts to Prohibit MEP by Federal Law	-105-
Research Difficulties	-107-
Predictors of Prevalence in Any Given State	-109-
Access to Information About MEP	-111-
What Safeguards Exist to Prevent Financial Exploitation by Relatives or Other Representatives?	-112-
Studies from Other States or on National Level	-115-
1. US GAO 1993 Report: Medicaid Estate Planning	-115-
2. Braceland Center for Mental Health and Aging (Walker and Gruman, 1996, and Walker, Gruman and Robison, 1998)	-116-
3. Minnesota Department of Human Services Quality Initiatives Division	-116-
4. Illinois Long Term Care Asset Discovery Initiative	-117-

5.	Massachusetts Study on Transfer of Assets by the Community Spouse	-118-
	
	Chapter 10: Results from Studies of County Medicaid Eligibility Workers in Ohio	-119-
	
	Techniques Used to Circumvent Provisions of OBRA 1993	-119-
	Portrait of a Medicaid Applicant	-122-
	Focus Group Sessions	-125-
	Attitude and Opinion Poll	-126-
	Chapter 11: Observations and Summary	-141-
	Medicaid Estate Planning and Asset Divestiture	-141-
	Medicaid Estate Recovery	-142-
	Connections: Eligibility Criteria, Policies to Deter Medicaid Estate Planning, and Medicaid Estate Recovery	-143-
	Conclusion	-146-
	Supplemental Information	-147-
	Appendix A: Criteria to Evaluate the Desirability of Proposed Estate Recovery Changes	-148-
	Appendix B: August & Sept., 1998 CDHS Tracking Sheet and Instructions	-150-
	Appendix C: “Study on Transfer of Assets and the Medicaid Estate Recovery Program” (House Bill 215, Section 67.08.)	-156-
	Appendix D: Ohio Revised Code, Section 5111.11, authorizing Ohio’s Medicaid Estate Recovery Program	-157-
	Appendix E: Ohio Revised Code, Section 5111.111, authorizing use of liens in Ohio’s Medicaid Estate Recovery Program	-158-
	Bibliography	-159-
	Glossary	-162-
	Acronyms	-168-

Executive Summary

Legislative Request

This study fulfills the mandate from the General Assembly of Ohio at section 67.08 as part of H.B. 215:

“Study on Transfer of Assets and the Medicaid Estate Recovery Program”

The Department of Human Services shall conduct a study, or contract for a study to be conducted, for the purpose of determining the extent to which applicants for nursing home services paid for through the Medicaid program are transferring their assets for less than fair market value as a means of avoiding depletion of their assets for their own support prior to becoming eligible for Medicaid. The study shall include an analysis of the Medicaid estate recovery program, including a compilation of data regarding the following: 1) the frequency of homestead property being available for recovery, 2) the amount spent on the estate recovery program in comparison to the amount actually recovered, and 3) the experience of other states in operating Medicaid estate recovery programs. The study shall include any recommendations for legislative changes that would either deter the occurrence of pre-eligibility asset transfers or enhance the efficacy of the Department's Medicaid estate recovery program. Results of the study shall be filed by January 1, 1999, with the Governor, the Speaker of the House of Representatives, and the President of the Senate.

The scope of this study encompasses three distinct areas of Medicaid policy that involve three phases of Medicaid participation:

- (1) “before”, including policies regarding actions such as the transfer of assets prior to Medicaid application,
- (2) “during”, involving the financial criteria for initial application and continued financial eligibility for Medicaid long term care benefits; and
- (3) “after”, involving Medicaid estate recovery policy.

Chapter 1: Introduction

The introductory chapter places the purpose of this study within the framework of federal efforts to control escalating growth in Medicare and Medicaid entitlement spending. The legislative changes in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) aimed to 1) curtail the practice of Medicaid Estate Planning, and 2) require states to operate Medicaid Estate Recovery programs to recoup some of the costs of providing Medicaid. Events leading to these changes provide the basic foundation for the introduction.

Medicaid and Medicare have not evolved in the way legislators expected

In 1965, Medicaid was initially envisioned as a program for the “medically indigent”, and Medicare was seen as the health care entitlement for the elderly. The two programs have not evolved in the way those legislators expected. The most expensive population of Medicaid eligible consumers in Ohio are the elderly and others with chronic disabilities who require long term care at home or in specialized facilities. Eleven percent of Ohio Medicaid recipients were aged, but they accounted for 35.5% of program spending in state fiscal year (SFY) 1995. Non-aged recipients who are disabled or blind made up just 13% of the Medicaid population, but accounted for 39.1% of spending.

Medicaid is the major payer for long term care facilities in Ohio and in the country

In 1993, Medicare paid for \$5.5 billion of the cost of nursing home care across the country, while Medicaid's share was \$23.3 billion. Medicaid is in fact the major payer for long term care. According to cost reports filed by all Medicaid certified nursing facilities in Ohio for calendar year 1997, Medicaid was responsible for funding 69.56% of all days of nursing home services delivered. Medicare's share was only 7.2%.

Many people using Medicaid for long term care were not always, or are not poor

Medicaid plays such a major role in funding long term care because nursing home care, long term home care, and institutional services for the mentally retarded are not often covered by regular health insurance policies. Medicare, contrary to the widespread belief of the general public, has very limited nursing facility coverage and home care benefits. Long term care insurance is expensive, and the design and market for this product is still under study. The lack of attractive and viable coverage options, combined with the ever increasing costs of delivering long term care, have increased the attractiveness of the Medicaid program to the middle and upper classes.

For some of the non-poor, rapidly depleting most of their own resources for nursing home care has necessitated converting to Medicaid from private pay status. They were not always poor. For others, the Medicare Catastrophic Coverage Act of 1988 (MCCA) mandated special Medicaid eligibility rules for couples when one member needs nursing home care. For married couples, Medicaid for long term care has become a middle-class benefit.

Chapter 2: Study Methodology

The second chapter provides a brief overview of how the study was conducted. Library research, collection of data from other states, study group meetings and presentations, focus groups, questionnaires, and evaluation of program operation, through interviews and direct observation, were used to gather the material presented.

Chapter 3: Performance of Ohio's Current Medicaid Estate Recovery Program

This chapter of the report examines the performance of Ohio's estate recovery program since its beginning in 1995. It provides the history of why Ohio is the only state to use its Attorney General's Office (AGO) to actually operate the program.

Two tables illustrate the program's performance thus far. For the scoffers who did not think estate recovery could recoup enough money to make it worth the effort, the data indicates otherwise. As of the end of June 1999, Ohio has collected \$17.6 million dollars, despite the minimal resources devoted by the state to operate the program. Put in another context, the money recouped through Medicaid Estate Recovery from December 1995 through June 1999 has been enough to completely fund the full year stay in an Ohio nursing home for 405 people.

These are impressive results, especially when one considers that Ohio is recovering only from estate assets that would or could go through probate, or from the remnants of nursing residents' personal needs allowance accounts. Although permitted by law, the program is not applying liens. Finally, Ohio's proactive policy requiring sale of homestead property after a six month absence from the home differs from most other states, and results in estate recovery collections that may be somewhat reduced in comparison.

Comparing Ohio's results to other states as a ratio of amounts recovered to total Medicaid expenditures, Ohio is among the ten lowest states, signaling that the program has the potential to recover far more than it has to date. While states on average report recovering 0.26% of total Medicaid expenditures, that amount for Ohio in 1997 was only 0.06%. In calendar year 1997 Ohio collected \$ 3.6 million. If Ohio's program yielded collections at the rate of the national average, Ohio would have collected \$15.1 million during that year alone. Another Midwestern state of comparable population, Illinois, collected \$16.3 million in their SFY 1996 and \$19.2 million in SFY 1997.

This chapter concludes by listing several design and operational factors that hinder Ohio's estate recovery program's potential to maximize collections.

Chapter 4: Design Issues of State Medicaid Estate Recovery Programs

This chapter analyzes the options provided by federal law and guidelines for implementing an estate recovery program, describes what other states are doing, and examines national studies and surveys. Each major design decision point is reviewed, including mandated target populations, scope of recovery, restrictions on recovery action, waivers for undue hardship, and the importance of a state's chosen definition of estate. Ohio's current collection procedures are briefly described, and the chapter closes by describing other states' practices that enhance recovery efforts.

Chapter 5: Use of Liens to Enhance Recovery Efforts

The chapter begins with an in-depth review of the differences in federal law between "TEFRA" liens, referring to provisions made by the Tax Equity and Fiscal Responsibility Act of 1982, and the other kind of liens imposed only after the death of a recipient. Federal law details complex restrictions outlining when liens are prohibited, when they must be dissolved, and when there are limitations placed on recovery efforts.

A discussion follows about how Ohio and only a handful of other states handle eligibility policy about homestead property, and how this policy impacts the estate recovery program. The frequency of homestead property being available for recovery is estimated as Ohio's estate recovery program is now operated.

The chapter takes a closer look at how use of liens per federal law impact HCBS waiver enrollees, and compares that to current Ohio law. Although liens can be a powerful tool in tracking and recovering assets, widespread misinformation about federal restrictions and permissible state actions has hindered their use thus far in Ohio.

Chapter 6: Key Concepts of Basic Medicaid Eligibility for the Aged-Blind-Disabled (ABD) Population

As an introduction to the most basic concepts of Medicaid eligibility criteria, this chapter summarizes issues such as how one is determined to be aged, blind, or disabled, and factors such as citizenship, residency, and acceptable living arrangements. This chapter also describes how a Medicaid applicant's income and resources are considered in determining eligibility for the ABD population, if they are not going to reside in a long term care facility or participate in a Medicaid home care waiver.

Chapter 7: Key Concepts of Medicaid Eligibility for Persons Cared for in Long Term Care Facilities or Enrolled on Waiver Home Care Programs

Medicaid eligibility is significantly more complex for persons who use Medicaid long term care services. This chapter explores the differences between the criteria used for persons in the community, and those needing long term care. The changes to federal law in 1988 that aimed to prevent spousal impoverishment made Medicaid criteria quite different for singles than for spouses. The criteria and procedures for “resource assessments,” calculating maximum and minimum allowances to protect the income and resources of the community spouse, and the institutionalized spouse’s monthly budget while in the nursing home are included here.

Chapter 8: “Striking It Poor”: Policies Regarding the Transfer of Assets Prior to Medicaid Application

This chapter examines in depth the policy that was refined through OBRA ‘93 to curtail practices of Medicaid estate planning, and provides a cursory overview of the most widely used vehicles used to shelter or transfer assets. The first section examines transfers of assets for less than fair market value, and how detection of this practice by the state can result in a defined period of restricted eligibility (during which Medicaid is not permitted to cover long term care services). Next, Medicaid eligibility policy as it currently exists in Ohio is examined in relation to land contracts, life estates, trusts, and annuities.

Chapter 9: Medicaid Estate Planning and Divestiture of Assets

MEP involves many strategies of converting assets, sheltering assets, transferring assets, and diverting assets. Access to information about these strategies is easier than ever to find, given the growing legal specialty of elder law, and with Internet access providing productive searches. The practice of MEP is examined from several angles in this chapter. The enticement to engage in MEP has all the makings of a classic social dilemma, in which the outcome of a person pursuing his or her own rational self interest may actually be harming the outcome of the community as a whole. Congress has twice been unsuccessful in legislating a sanctioned prohibition of the practice, and this legislative and judicial history is discussed.

While much has been written about MEP, national and state researchers attempting to accurately measure the extent of this practice fall short due to predictable realities. The frequency and numerous methods of MEP used by potential applicants and recipients is hard to measure empirically. People who have participated in strategies to access a benefit that they were not intended to receive rarely want to relay their actions to others. For this reason, one of the best

sources of information on the subject is the caseworker at the county department of human services who processes the Medicaid application.

Factors that may lead one state, or one region in a state, to have more MEP activities than others are examined. A series of variables illustrating how Ohio ranks with the rest of the nation shows that Ohio's risk is at least average and in some variables much higher than other states. For instance, Ohio ranks high in the prevalence of nursing home beds and as a percentage of elderly in nursing homes. Nursing home expenditures per person age 65 and older is also high. Ohio ranks in the mid ranges for projected demand for total long term care and for public long term care. While these variables compare Ohio to the rest of the country, they do so within the context of the changing demographics everywhere in the U.S.A., in which the most rapidly growing age cohort is age 85 and older.

Findings from other studies are summarized, including the U.S. General Accounting Office report in 1993 that thoroughly reviews the various MEP strategies, and the most recent one completed in Connecticut that reports interview results with Medicaid eligibility workers, elder law attorneys, and financial planners. In Connecticut, the majority of all three groups (68.6% overall) report that they think asset transfers have increased over the past six years.

Chapter 10: Results from Studies of County Medicaid Eligibility Workers in Ohio

A chapter of this study is devoted to research conducted with Ohio eligibility workers from most of the counties of Ohio. Various forms of research lead to the conclusion that divestiture or conversion of assets for the purpose of becoming artificially Medicaid eligible is indeed problematic for Ohio. For example, 81% of the workers have seen in their own caseloads the practice of unrestricted asset transfers, three years in advance of application. Workers reported that 89% had seen cases in which persons paid their adult children for assistance in meeting their daily needs, 93% have seen the purchase of exempt assets from resources that were considered countable, and 50% have observed persons using the strategy of giving away half their assets, so that the remainder of their assets can be used to fund long term care during the "look-back" period. (This technique prevents the person from invoking any period of restricted Medicaid eligibility.)

As seen in other states, Medicaid estate planning is not evenly distributed, and different strategies are favored more in some areas than others. Workers in focus group discussions reported their extreme frustration, as they watch most of the applicants playing by the rules, while others skillfully gain access to Medicaid eligibility in spite of their wealth. Attempts by family members to "latch onto their inheritance" by MEP strategies, or to prevent their parents from accessing necessary services in light of Medicaid Estate Recovery provisions, were also noted.

Medicaid workers in the Cleveland and Columbus districts painted a portrait of the typical applicant who uses MEP strategies. Their profile is remarkably similar to ones drawn in Connecticut by that state's eligibility workers, elder law attorneys, and financial planners. While over 90% of Connecticut interviewees report that the typical applicant they see using MEP strategies owns their own home and holds no mortgage, 93% of Columbus district workers report the typical applicants own their own home, and 86% report that typically there is no mortgage. In Cleveland, 70% report home ownership, with 90% reporting that typically there is no mortgage.

Chapter 11: Observations and Summary

Legislators, providers, and caseworkers have suspected that a combination of factors has led to the practice of Medicaid Estate Planning (MEP), in which eligibility rules are manipulated by non-poor persons to avoid using their own assets to pay for long term care, thereby shifting this cost to the taxpayer. MEP is a complex concept. It involves practices that may not be illegal, although many consider the actions unethical, or, at best, a distortion of program intent. The practice has serious equity repercussions, as benefits targeted to the poor may have to be curtailed because certain middle and upper class elders and their heirs receive public benefits.

The summary chapter includes a look at the connections between estate planning and estate recovery, and why sound Ohio Medicaid policy design demands attention to both topics. A table outlines reasons why focus is needed at both the point of application for Medicaid and when the individual is deceased. The efforts to deter Medicaid estate planning during eligibility determination processes do not uncover the same type of assets that are found during estate recovery. Reasons that hinder Ohio's performance in its estate recovery program related to design and operation are also reiterated here.

Chapter 1: Introduction

Statement of the Purpose of this Report

In 1993, Congress was faced with burgeoning health care costs and pressure to reduce deficit spending. From that year's Omnibus Budget Reconciliation Act (OBRA) came a new mandate for states administering Medicaid programs. Congress mandated that states set up "Medicaid estate recovery" programs to make claims and pursue recovery from the estates of certain Medicaid recipients for benefits paid on their behalf. Allowing states and the federal government to recoup some of the taxpayers' money invested in Medicaid was seen as helping to reduce the escalating cost of one of the largest and fastest growing government programs. This legislation (OBRA 1993) also attempted, once again, to close loopholes used by non-poor applicants to become Medicaid eligible through techniques collectively referred to as "Medicaid estate planning"(MEP).

Prior to 1993, states had a federally enacted option to operate Medicaid estate recovery programs. The success of Oregon and other states electing this option persuaded the General Accounting Office to recommend to Congress that significant sums could be raised by an "estate recovery" mandate. Other states, including Ohio, had not chosen to operate an optional program, and cited reasons such as the cost effectiveness of recovery and the controversial nature of taking such actions.

To comply with OBRA 1993, Ohio passed laws to implement the mandated estate recovery program for persons using Medicaid benefits who died after January 1, 1995. The state began the program with low expectations for recovery and a keen trepidation, aware of the complexity of entering the arena of estate and probate law to intervene during these emotion laden processes. There are high stakes in the distribution of potential inheritances and settling of other debts.

On the one hand, Medicaid estate recovery could interfere with the desire of recipients to leave their loved ones a legacy. Working hard and having something to leave for "the kids" is a predominant value of American citizens. Estate recovery would turn Medicaid from an entitlement program into a guaranteed health care loan, and restrict the ability of participants to leave an inheritance. On the other hand, Medicaid was supposedly a means-tested program, and

many wondered whether the seemingly tight restrictions on eligibility left recipients with any sizable assets to be recovered or inherited.

Ohio designed its estate recovery program in 1995 as conservatively as possible. It did not elect to utilize federal options that could expand the probate definition of estate to include other types of assets. It also limited collection to benefits paid for only the mandated set of services, not the entire list of claims paid by Medicaid for the recipient.

Yet, as we prepare for the new millennium, the same decisions facing Congress in 1993 face Ohio. Burgeoning populations of elderly and other people with disabilities have growing health care needs, and higher technology options are available for treatment. These groups and their families are demanding more expensive and innovative services in friendlier, non-institutional settings. The costs to serve these populations compete for allocation of scarce governmental resources with other also-legitimate needs, such as education, transportation and other infrastructure, and law enforcement.

Medicaid in Ohio is one of the state's largest budget items, and within Medicaid, the people using nursing facility (NF) programs, intermediate care facilities for the mentally retarded (ICFs-MR) programs, and long term waiver home care programs, such as PASSPORT, are spending more per capita than other consumers. ODHS and the state of Ohio must ask these difficult questions: Is "Medicaid estate recovery" a way to generate significant revenues in a cost effective way to help replace these state expenditures? Is Medicaid in Ohio appropriately targeting its resources to provide services to those persons who really are poor?

Long Term Care Overview and Trends

"Long term care " refers to a broad range of medical, social, personal care, and supportive services needed by individuals who have lost some capacity for self-care because of a chronic illness or condition. Long-term care services are usually differentiated by the settings in which they are provided, with services either in nursing homes and other institutions or in home and community-based settings.

Medicaid Has Evolved into the Primary Payer for Long Term Care

The Medicaid program was established in 1965 as a program for the "medically indigent." Medicare's birth at the same time was envisioned as a comprehensive health coverage program for the elderly. Yet Medicaid has long since evolved into the *PRIMARY* payer for institutional long term care in nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR). Medicare's benefit package focused more on acute and ambulatory care.

Many People Using Medicaid for Long Term Care Were Not Always, or Are Not Poor

Program analysts discovered that recipients of Medicaid who use long term care services often had significantly different financial backgrounds from the recipients who were eligible for Medicaid through their participation in the Aid for Families with Dependent Children (AFDC) program (now Temporary Assistance for Needy Families (TANF)). Many came from the middle classes, owned real estate free and clear, and held assets in banks, bonds, trusts, insurance policies, and other places. The high costs of long term care resulted in many who spent their resources for NF stays and home care, and became poor enough to meet Medicaid eligibility criteria.

Additionally, thanks to the law Congress passed in 1988 that alleviated the severe problems of “spousal impoverishment” when long term care was needed by a spouse, married recipients of long term care and their immediate families are now able to receive Medicaid benefits while still retaining considerable real and liquid assets.

Delivery of LTC Services

The long term care service delivery system in Ohio, like the entire nation, is a blend of 1) formal institutional care or formal in-home and residential care (e.g., assisted living) paid by a blend of governmental, insurance and private funds, and 2) informal home care provided by unpaid caregivers. According to a federal report, “Almost three-quarters of long-term spending for the elderly is for nursing home care. Two sources of payment—the Medicaid program and out-of-pocket payments—account for nearly 90% of this total...Medicaid program data show that spending for the elderly is driven largely by its coverage of people who have become poor as the result of depleting assets and income on the cost of nursing home care.... While most persons needing long-term care live in the community and not institutions, comparatively little long-term care spending is for the home and community-based services that the elderly and their families prefer. ...Studies have found that about 65% of functionally impaired elderly living in the community rely exclusively on unpaid sources, generally family and friends, for their care. Surveys have found that eight out of ten caregivers provide unpaid assistance averaging 4 hours a day, 7 days a week.”¹

¹ U.S. Congress, “Long Term Care Policy Study,” Congressional Research Services Issue Brief, (March 22, 1995), pp. 3-4.

Current Distribution of Financing of Long Term Care

As indicated by a Congressional Research Issue Brief, the nation already spends a great deal of money on long-term care for the elderly—nearly \$80 billion in 1993. Federal and state governments account for the bulk of this spending, \$46 billion or 58% of the total.²

Elderly Long Term Care Expenditures In U.S.A. for Nursing Home Care by Source of Payment 1993	
Medicaid	\$23.5 billion
Medicare	\$ 5.5 billion
Other Federal (e.g., Veteran's Admin.)	\$ 0.7 billion
Other State and local	\$ 0.6 billion
Out-of-pocket payments and other	\$28.2 billion
Private Insurance	\$ 0.1 billion
TOTAL	\$ 58.6 billion

Within the framework of Ohio's Medicaid program in state fiscal year (SFY) 1995, eleven percent of Ohio Medicaid recipients were aged, but they accounted for 35.5% of program spending. Recipients who are disabled and blind made up just 13% of the Medicaid population, but accounted for 39.1% of spending.³ According to cost reports filed by nursing facilities in Ohio in 1997, Medicaid was responsible for funding 69.56% of all days of nursing home services delivered. Medicare's share was only 7.2%.

Current Cost Containment Strategies

Medicaid objectives include controlling the escalating costs of delivery of long term care. Ohio is currently using all the state-of-the-art strategies to accomplish this by controlling the three main areas that drive health care costs.

- √ The Medicaid program controls access into the system through its pre-admission screening services for both public and private users of long term care. This program is

² "Long Term Care Policy Study," p. 2.

³ Ohio, Ohio Medicaid Report, The Ohio Department of Human Services, January 1997, pp. 4-9 and 4-10.

administered by the Ohio Department of Aging's PASSPORT program and other designees.

- √ Addition to the supply of NF beds requires a certificate of need issued through the Ohio Department of Health. The supply of ICF-MR beds is capped and controlled by the Ohio Department of Mental Retardation/ Developmental Disabilities.
- √ The Ohio Medicaid program also works diligently to control cost and to be a prudent purchaser of long term care through use of prospective payment systems based on resident assessment data that measure acuity of needs.

In addition, it should be noted that institutional long term care is one of, if not the most, regulated industries in the country in order to insure the health and safety of its vulnerable customers.

Long Term Care Insurance

Long term care insurance paid for only two-tenths of one percent of the cost of nursing home care in 1993.⁴ Joshua Weiner recently testified to the Special Committee on Aging, United States Senate, on the topic, "Can Private Insurance Solve the Long Term Care Problems of the Baby Boom Generation?". At that time he remarked:

Although over 95 percent of the elderly have Medicare coverage and about 70 percent have supplemental private insurance policies, insurance against the potentially devastating costs of long term care is relatively rare. As of the end of 1995, only 4.3 million long term care policies ever had been sold (although far fewer were in force), overwhelmingly to the elderly on an individual basis rather than to younger people on an employer-subsidized group basis.

By far the greatest impediment is the high cost of good quality policies. Despite the marked improvement in the financial position of the elderly over the past twenty years, long term care insurance remains unaffordable for most elderly. The average annual premium for policies covering four years of nursing home and home care with inflation protection and nonforfeiture benefits in 1995 was \$1,124 per year if purchased at age 50, \$2,560 per year if purchased at age 65, and \$8,146 a year if purchased at age 75.

....Given the limitations of the current market for private long term care insurance, public subsidies to promote its purchase are frequently proposed. One approach is to provide employers a tax subsidy for the purchase of long term care insurance policies for their employees by allowing them to deduct insurance contributions as

⁴ "Long Term Care Policy Study," p. 3.

a business expense. A second strategy is to provide a tax deduction or credit to individuals for purchase of private long term care insurance. ...A final strategy is to waive some or all of the Medicaid asset depletion requirements for purchasers of qualified private long term care insurance policies, an approach being tried in several states. The shared intent of these strategies is to induce more people to purchase policies by lowering premium costs through tax breaks or guaranteeing publicly-funded coverage once privately purchased coverage is exhausted. Proponents argue that a key consequence of any of these actions is public endorsement of the importance and desirability of private long term care insurance.⁵

Weiner cautions, however, that while these options may indeed promote insurance purchase, they do not come without a price. Revenues not otherwise collected, as a result of tax incentives and asset protection plans, cost the government as surely as do the direct cost of expenditures through Medicare and Medicaid.

Policy Ambiguity: the Private and Public Responsibilities for Long Term Care

At the time in 1993 that Congress, the Inspector General, and General Accounting Office were grappling with the nation's deficit reduction policy options related to Medicaid programs, the congressional report about Medicaid estate recovery cited the following:

Changing the estate recovery processes and rules would have two main advantages. First, it would reduce Medicaid spending as more people used private resources to defray their nursing home costs, and as Medicaid payments for long term care services were recovered from the estates of beneficiaries. Second, lien programs could enable relatives who might otherwise have sold a beneficiary's home to pay for long-term care to buy this care instead at Medicaid rates and still retain use of the house during their lifetimes.⁶

Brian Burwell has extensively studied the issues of Medicaid eligibility, estate planning and estate recovery. He notes:

Our current long term care policy, as expressed through Medicaid policy—the primary public source of financing long term care services—reflects a mishmash of ambivalence about public and private responsibilities for long term care. Further,

⁵ Joshua M. Weiner, "Can Private Insurance Solve the Long Term Care Problems of the Baby Boom Generation?," Testimony presented at "The Case Crunch: The Financial Challenge of Long Term Care for the Baby Boom Generation," a hearing held by the Special Committee on Aging, United States Senate, Washington, D.C., March 9, 1998.

⁶ U.S. Congress, "ENT-32 Tighten Medicaid's Estate-recovery Processes and Rules for Long-term Care," CBO Deficit Reduction Policy Options Relating to Medicaid Programs, Congressional Budget Office Report, Feb. 1, 1993.

our current policy has created a system of such ambiguity that the well-heeled and well-informed often get more financial assistance from the general public than the truly poor, who do not know how to “work the system.” In brief, the ambiguity of current policy also creates inequities in how public resources are allocated to people who require assistance with long term care.⁷

Indeed, a brief look at the various demands on the Medicaid program, their interdependence, and their contradicting goals illustrates the dilemma of conflicting policy objectives and the likelihood of the creation of perverse incentives. Medicaid as a funding and delivery system for long term care has been expected to remain as a means-tested program, yet provide wide-reaching financial protections for a community spouse. At various times, the policy goals of the estate recovery provisions have been aimed at:

1. Prevention of abuse of the Medicaid system by “rich” (i.e., non-poor) persons by cutting off their ability to “game the system”;
2. Promoting cost containment (i.e., maximum recovery from all possible beneficiaries);
3. Discouraging the use of nursing homes (by focusing estate recovery under pre-OBRA 1993 law on only institutionalized residents);
4. Discouraging the use of all long-term care benefits (by the OBRA 1993 mandate’s broad scope of mandated services); and
5. Encouraging the purchase of long-term care insurance.⁸

The Congressional Report notes three branches of opinion on the proper public and private balance in financing long term care services:

Some persons advocating a public sector solution argue that all persons at one time or another are at risk of needing long-term care and this risk can be shared most efficiently and at least cost by a social insurance program, like Medicare...Social insurance advocates also argue that the need for long-term care is no different from the need for medical care; the elderly are not expected to impoverish themselves when they need medical care and should not be expected to do so when they need long-term care.

⁷ Brian Burwell and William H. Crown, “Medicaid Eligibility Policy and Asset Transfers: Does Any of This Make Sense?”, Generations, (Fall 1996) , 78.

⁸ Roger A. Schwartz and Charles P. Sabatino, “Medicaid Estate Recovery under OBRA ‘93: Picking the Bones of the Poor?” Commission on Legal Problems of the Elderly, The American Bar Association, (Nov. 1994), pp. 5-6.

Private sector advocates, on the other hand, argue that the country cannot afford the tax burden associated with another entitlement program like Medicare. They also argue that, since many elderly persons need long term care at the end of their lives, a new public entitlement that is not means-tested like Medicaid could have the effect of using scarce public resources to protect assets for younger generations. For this reason, they maintain that long term care is an individual and family responsibility that persons should include in their general financial planning...Still others argue that the cost of long term care must be shared by both the public and private sectors if a solution is to be found.⁹

Burwell and Crown conclude their paper on Medicaid Eligibility Policy and Asset Transfer by observing that:

In theory, our country has a long term care policy which stipulates that the financing of long term care services is primarily a private responsibility, with the Medicaid program serving as a safety net for people who cannot afford to buy formal long term care services and for people who have depleted their own resources on the costs of long term care, particularly nursing home care. In reality, our long term care policy draws no such clear dividing line where private responsibilities end and public responsibilities begin. This ambiguity occurs because of the way in which Medicaid policies regarding financial eligibility criteria, penalties on asset transfers, and Medicaid estate recovery programs are operationalized.

The conflicting objectives of keeping Medicaid a means-tested program and providing financial protections for a community spouse have resulted in a situation in which fairly restrictive financial criteria are applied to single Medicaid applicants, while married couples are provided relatively generous protections.

Regardless of where our government decides to draw the line, the division of private versus public responsibilities for financing long term care services needs to be drawn more boldly. For taxpayers, politicians want to provide the impression that we have a cost-conscious Medicaid program that only assists those who truly cannot afford to pay their own way; for beneficiaries, politicians want to impart a more generous message. The end result is a Medicaid program that tries to have it both ways. It doesn't work.¹⁰

⁹ "Long Term Care Policy Study," pp. 4-5.

¹⁰ Burwell and Crown, "Medicaid Eligibility Policy and Asset Transfers: Does Any of This Make Sense?", p. 83.

Chapter 2: Study Methodology

As noted in the Acknowledgment section, this study was conducted within the Department of Human Services. Given limited staff time and fiscal resources, the study was conducted as described below.

Surveyed Literature and Internet

Research at the State Library and Internet searches for materials about both Medicaid estate recovery programs and the practice of Medicaid estate planning were conducted. Numerous national studies and articles exist about these topics, as well as informative Internet sites that offer state-specific information on Medicaid eligibility and estate recovery.

Canvassed County Eligibility Workers

One of the best sources for information on the prevalence of applicants who use Medicaid estate planning techniques to become Medicaid eligible is the local county department of human services (CDHS). Medicaid eligibility workers stationed at the CDHS process the applications and make financial eligibility determinations. As part of the study, we were able to meet face to face with workers and supervisors from four of the five districts of ODHS (Cleveland, Columbus, Cincinnati, and Toledo).

Eligibility staff from each district were asked to complete an attitude and opinion poll. They were asked to list the techniques observed in their own caseload which suggested Medicaid estate planning was used. In two districts, workers were asked to complete a portrait of their typical Medicaid applicant for long term care services, using the same template as a recently completed national study.¹¹

¹¹ Leslie Walker, Cynthia Gruman, and Julie Robison, "Medicaid Estate Planning: Practices and Perceptions of Medicaid Workers, Elder Law Attorneys, and Certified Financial Planners," *The Gerontologist*, Vol. 38, No. 4, (1998), 405-411.

The largest undertaking by the eligibility workers was to track aspects of the applications they approved or denied, and note other specific case actions taken during July, August and September of 1998. No aggregate information capturing the proportion of approved and denied cases by specific variables has been available until this time.

Collected Estate Recovery Program Information from Other States

Letters were written to all other states' Medicaid programs to solicit copies of those states' estate recovery program law, rules, brochures, state plan amendments, and any other noteworthy materials. The study collected information from 44 states. Four states were not operating estate recovery programs at that time.

Studied Ohio's Estate Recovery Program Operations

An in-depth analysis of the operations of Ohio's current estate recovery program was conducted, to evaluate the program since its origin in January 1, 1995. The evaluation process included: 1) direct observation of activities by the Assistant Attorney General and account representatives in the Revenue Recovery Unit of the Attorney General's Office, which spearheads recovery efforts; 2) interviews with the ODHS Fiscal Office staff; 3) review of existing and pending state plan amendments, public assistance manual materials, and Ohio Administrative Code; and 4) review of existing state and federal law in a compliance review.

Convened Study Group

As part of the study, ODHS called together a group of persons who represented particular segments of the long term care industry, advocacy groups, legal associations, and other state agencies. The group was convened to learn more about the issues, discuss practices and study options. Three subcommittees were formed from this study group that met at additional times to delve deeper into these complex issues. A Subcommittee on the Estate Recovery Program studied research on Estate Recovery conducted by national groups, and ways that an estate recovery program are operationalized in other states. This subcommittee created a criteria list which appears in Appendix A to evaluate any proposed changes as they might impact the numerous and divergent policy goals.