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May 2014

# MEDICAID

## Financial Characteristics of Approved Applicants and Methods Used to Reduce Assets to Qualify for Nursing Home Coverage

# GAO Highlights

Highlights of [GAO-14-473](#), a report to congressional requesters

## Why GAO Did This Study

Medicaid paid for nearly one-third of the nation's \$158 billion in nursing home expenditures in 2012. To be financially eligible for Medicaid, individuals cannot have assets above certain limits. Not all assets are countable in determining Medicaid eligibility; federal law discourages individuals from reducing their countable assets, for example by transferring them to family members, to qualify for Medicaid. Although Congress has acted multiple times to address financial eligibility requirements for Medicaid coverage of nursing home care, methods exist through which individuals, sometimes with the help of attorneys, can reduce their assets and qualify for Medicaid.

GAO was asked for information on the extent to which individuals may be using available methods to qualify for Medicaid coverage. GAO (1) examined financial characteristics of applicants approved for Medicaid nursing home coverage in selected states; (2) identified methods used to reduce countable assets to qualify for Medicaid; and (3) identified information eligibility workers consider the most useful in assessing applicants' financial eligibility. GAO analyzed a random, but nongeneralizable, sample of Medicaid nursing home applications in two counties in each of three states (Florida, New York, and South Carolina), selected based on several factors including states' asset verification efforts and demographics. GAO also interviewed officials from the Centers for Medicare & Medicaid Services, state Medicaid officials, county-based Medicaid eligibility workers, and attorneys.

View [GAO-14-473](#). For more information, contact Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

May 2014

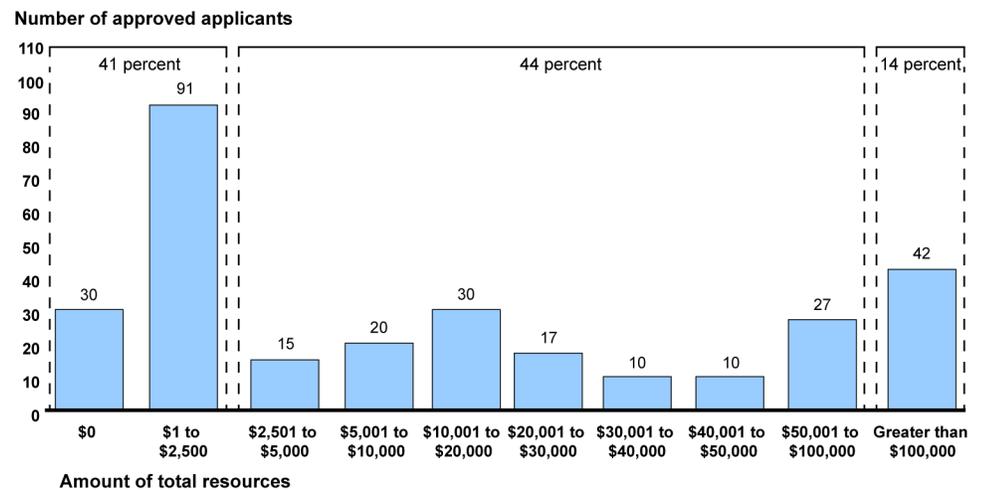
## MEDICAID

### Financial Characteristics of Approved Applicants and Methods Used to Reduce Assets to Qualify for Nursing Home Coverage

## What GAO Found

GAO's review of 294 approved Medicaid nursing home applications in three states showed that 41 percent of applicants had total resources—both countable and not countable as part of financial eligibility determination—of \$2,500 or less and 14 percent had over \$100,000 in total resources.

**Distribution of Approved Applicants in Selected Counties in Three States by Amount of Total Resources (n=294)**



Source: GAO analysis of Medicaid application data.

Note: Data were from applications submitted during state fiscal year 2012 or between July 1, 2012, and December 31, 2012. Amount of resources may be understated as the value of certain resources was not available. For two applicants, no values were available, thus percentages do not add to 100.

Nearly 75 percent of applicants owned some noncountable resources, such as burial contracts; the median amount of noncountable resources was \$12,530.

GAO identified four main methods used by applicants to reduce their countable assets—income or resources—and qualify for Medicaid coverage:

1. spending countable resources on goods and services that are not countable towards financial eligibility, such as prepaid funeral arrangements;
2. converting countable resources into noncountable resources that generate an income stream for the applicant, such as an annuity or promissory note;
3. giving away countable assets as a gift to another individual—such gifts could lead to a penalty period that delays Medicaid nursing home coverage; and
4. for married applicants, increasing the amount of assets a spouse remaining in the community can retain, such as through the purchase of an annuity.

Eligibility workers GAO spoke with identified bank statements as the most useful source of information for assessing financial eligibility. They explained that bank statements could lead to the identification of unreported assets, such as life insurance policies, or show patterns of withdrawals that prompt further inquiry.

The Department of Health and Human Services provided technical comments on a draft of this report, which GAO incorporated as appropriate.

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## Abbreviations

AVS	asset verification system
CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FMV	fair market value
HHS	Department of Health and Human Services
SSI	Supplemental Security Income

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May 22, 2014

The Honorable Tom Coburn, M.D.  
Ranking Member  
Committee on Homeland Security and Governmental Affairs  
United States Senate

The Honorable Richard Burr  
Ranking Member  
Subcommittee on Primary Health and Aging  
Committee on Health, Education, Labor, and Pensions  
United States Senate

The Honorable Darrell Issa  
Chairman  
Committee on Oversight and Government Reform  
House of Representatives

The Honorable Trey Gowdy  
House of Representatives

Long-term care, particularly nursing home care, can be costly; in 2012, the estimated average annual cost for an individual to receive care in a nursing home was over \$85,000.<sup>1</sup> In that same year, nursing home expenditures in the United States amounted to \$158 billion, more than half of the nation's total spending for long-term care services. Medicaid—a joint federal-state health care financing program covering certain categories of low-income individuals—is the largest payer of long-term care services and accounted for 32 percent of nursing home expenditures in 2012. As the number of elderly Americans continues to grow and more individuals are likely to need long-term care, Medicaid spending for nursing home care is projected to increase, placing additional burden on already strained federal and state resources.

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<sup>1</sup>MetLife Mature Market Institute, *Market Survey of Long-Term Care Costs* (New York, N.Y.: November 2012). In addition to nursing home services, other health care services for long-term care include home health, personal care services, assisted living, and noninstitutional group living arrangements.

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Medicaid offers health care coverage, including coverage for long-term care services, to individuals whose assets—both income and resources—are insufficient to meet the costs of necessary medical services.<sup>2</sup> Individuals applying for Medicaid coverage for long-term care must meet certain financial and functional eligibility criteria.<sup>3</sup> To meet the financial eligibility criteria, individuals must have assets that fall below established standards, which vary by state, but are within standards set by the federal government. Not all assets are countable in determining financial eligibility for Medicaid. For example, states generally exclude—within specified limits—the value of an individual’s primary residence, car, and prepaid burial arrangements. Additionally, federal law includes provisions to discourage individuals from reducing their countable assets—for example, by transferring them to family members—in order to establish financial eligibility for Medicaid coverage. Specifically, those who transfer assets for less than fair market value (FMV) during a specified “look-back” period—a period of time before applying for Medicaid in which an individual’s or couple’s assets are reviewed—may be deemed ineligible for Medicaid coverage for long-term care for a period of time called the penalty period.

As the day-to-day administrators of the Medicaid program, states are responsible for assessing applicants’ financial eligibility for Medicaid coverage for long-term care; that is, determining whether an applicant’s countable income and resources are below the state-established standards, and whether an applicant transferred assets for less than FMV during the look-back period. The processing of Medicaid applications is generally performed by local or county-based eligibility workers. Our previous work found that, to determine eligibility, states generally required applicants to submit applications and provide documentation of certain

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<sup>2</sup>Assets include income, which is anything received during a calendar month that is used or could be used to meet food or shelter needs; and resources, which are anything owned, such as bank accounts or property, that can be converted to cash. This terminology is based on definitions provided in *The State Medicaid Manual* issued by the Centers for Medicare & Medicaid Services, which specifies that assets include both income and resources.

<sup>3</sup>This report focuses on financial eligibility. Individuals applying for Medicaid coverage for long-term care must also meet functional eligibility criteria established by each state. Functional eligibility criteria generally involve a degree of impairment measured by limitations in an individual’s ability to carry out certain activities of daily living, such as eating and dressing; and instrumental activities of daily living, such as preparing meals and grocery shopping.

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assets. States varied, however, in the amount of documentation required from applicants, the information they obtained from third parties to verify the accuracy of applicants' reported assets,<sup>4</sup> and in the proportion of applicants whom they identified as having transferred assets for less than FMV during the look-back period.<sup>5</sup> Some of the variation we found raised questions about whether states had sufficient information about applicants' assets to implement federal requirements. Additionally, our previous work identified methods individuals used to reduce assets to qualify for Medicaid coverage of long-term care that would not, or may not, result in a penalty period, as they would not be considered a transfer for less than FMV.<sup>6</sup>

Congress has acted on multiple occasions to address financial eligibility requirements for Medicaid coverage for long-term care. Most recently, the Deficit Reduction Act of 2005 (DRA), enacted in February 2006, amended some existing provisions regarding asset transfers and introduced new requirements related to financial eligibility for Medicaid coverage for long-term care.<sup>7</sup> For example, the DRA extended the look-back period from 36 months to 60 months for transfers occurring on or after its enactment, changed the calculation and timing of the penalty period for those transfers, and introduced new requirements for how certain types of assets—such as an individual's primary residence and an annuity—should be considered when determining Medicaid eligibility. Nevertheless, methods exist through which applicants, sometimes with the assistance of attorneys or financial planners, can reduce their assets in a manner consistent with existing law to qualify for Medicaid coverage.

Given our past work related to states' Medicaid financial eligibility determination processes, you asked us to provide information on the extent to which individuals may be using available methods to become eligible for Medicaid coverage for long-term care. In this report, we

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<sup>4</sup>GAO, *Medicaid Long-Term Care: Information Obtained by States About Applicants' Assets Varies and May Be Insufficient*, [GAO-12-749](#) (Washington, D.C.: July 26, 2012).

<sup>5</sup>GAO, *Medicaid Long-Term Care: Few Transferred Assets Before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility is Uncertain*, [GAO-07-280](#) (Washington, D.C.: Mar. 26, 2007).

<sup>6</sup>GAO, *Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage*, [GAO-05-968](#) (Washington, D.C.: Sept. 2, 2005).

<sup>7</sup>See Pub. L. No. 109-171, §§ 6011-6016, 120 Stat. 4, 61-67 (2006).

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(1) examine the financial characteristics of applicants approved for Medicaid nursing home coverage in selected states; (2) identify the methods used to reduce countable assets to qualify for Medicaid coverage for nursing home care; and (3) identify the information eligibility workers considered the most useful for identifying and verifying applicants' financial eligibility.

To examine the financial characteristics of applicants approved for Medicaid nursing home coverage in selected states, we reviewed a random sample of Medicaid nursing home application files in selected counties in three states. To select the states, we determined the extent to which all states took one or more of three actions to verify applicants' reported assets using results from a 2011 GAO web-based survey of Medicaid officials from each of the 50 states and the District of Columbia.<sup>8</sup> On the basis of this assessment, we ranked the states on the extent to which they reported taking these actions and placed them into three groups (low, medium, and high) using naturally occurring breaks in the data. We determined whether they could provide us with needed data in order to select a sample of application files from counties within the states. We then selected 3 states—1 from the low group (Florida) and 2 from the high group (South Carolina and New York). Within each state, we selected two counties that, relative to other counties in the state, had a large number of elderly individuals (aged 65 and older), high median income of elderly households, and a high number of Medicaid nursing home applications. In total, we reviewed 350 Medicaid application files, 294 of which were approved, including those that were approved and incurred a penalty period.<sup>9</sup> (See app. I for information about the applications reviewed.) From the 294 approved application files, we collected and analyzed data on applicants' assets (both income and resources), whether the resources were countable toward Medicaid eligibility, and whether applicants were found to have transferred assets for less than FMV. Our analysis was limited to information included in the

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<sup>8</sup>The three actions were the extent to which states reported they (1) verified applicants' assets with financial institutions; (2) conducted property record searches; and (3) obtained information covering the 60-month look-back period. See [GAO-12-749](#) for the results of this survey.

<sup>9</sup>The applications reviewed were of individuals aged 65 or older at the time they applied for Medicaid nursing home coverage. In Florida and South Carolina, we reviewed applications submitted in the state fiscal year ending in 2012 (July 1, 2011, through June 30, 2012). In New York, we reviewed applications submitted between July 1, 2012, and December 31, 2012, due to limitations in the state's data systems prior to that date.

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application files, which states used to make their eligibility determinations. We did not independently verify the accuracy of this information. However, we examined the data we collected for obvious errors and tested the data; based on this, we determined that the data were sufficiently reliable for the purposes of this report. The data from the 294 approved application files cannot be generalized to other approved applicants.

To identify the methods used to reduce countable assets to qualify for Medicaid coverage for nursing home care, we reviewed applicable federal laws and guidance, and spoke with officials from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees the Medicaid program. We interviewed nine attorneys recommended to us by the Director of the American Bar Association's Commission on Law and Aging and conducted undercover calls with representatives from 17 law offices whose websites indicated that they provided assistance to elderly individuals seeking Medicaid coverage for long-term care. We also interviewed state Medicaid officials from 12 states, and Medicaid eligibility workers from two counties in 6 of these 12 states, selected in part based on information collected from our interviews with attorneys, undercover calls with representatives from law offices, information from background literature, and demographic data on the population aged 65 and older. We supplemented this information with data collected from our review of Medicaid nursing home application files.

To identify the information eligibility workers considered the most useful for identifying and verifying applicants' financial eligibility, we used information from our interviews with county eligibility workers in two counties in each of the six states. (See app. II for more information about our scope and methodology.)

We conducted this performance audit from September 2012 to May 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigation standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

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## Background

To qualify for Medicaid coverage for long-term care, including nursing home care, individuals must be within certain eligibility categories—such as those who are aged or disabled—and meet functional and financial eligibility criteria. The financial eligibility standards differ based on whether an individual is married or single. Federal law also limits Medicaid payments for long-term care for individuals who have transferred assets for less than FMV during a specified time period. States are responsible for assessing applicants' financial eligibility for Medicaid.

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## Financial Eligibility for Medicaid Coverage for Long-Term Care

Common ways individuals become financially eligible for Medicaid coverage of long-term care, including nursing home care, are provided below.

- Supplemental Security Income (SSI). Individuals who participate in SSI, a program that provides cash assistance to aged, blind, or disabled individuals with limited income and resources, are generally eligible for Medicaid.<sup>10</sup>
- Medically needy. Individuals who incur high medical costs may be able to “spend down” their income below the state-determined income eligibility limit for Medicaid. Such individuals are referred to as “medically needy.” In 2012, 32 states and the District of Columbia had a medically needy option, although not all extended this option to those who needed nursing home care.<sup>11</sup>
- Special income level for residents of a nursing home or institution. Individuals can qualify for Medicaid if they reside in nursing facilities or other institutions in states that have elected to establish a special income level under which individuals with incomes up to 300 percent of the SSI benefit (300 percent of the benefit was \$2,163 per month in

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<sup>10</sup>Not all SSI recipients automatically qualify for Medicaid. Under Section 1902(f) of the Social Security Act, a state may use more restrictive Medicaid eligibility standards than SSI's standards, provided the standards are no more restrictive than those the state had in place as of January 1, 1972. As of March 2013, 11 states had opted to use these standards. These states are often referred to as 209(b) states because the origin of this provision was § 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1381.

<sup>11</sup>Medicaid and CHIP Payment and Access Commission, *Report to the Congress on Medicaid and CHIP, March 2013* (Washington, D.C.: Mar. 15, 2013).

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2014) are eligible for Medicaid. In 2012, 43 states and the District of Columbia had elected this option.<sup>12</sup>

Some states also allow applicants to place income in excess of the special income level into a qualified income trust and receive Medicaid coverage for their care.<sup>13</sup> This type of trust, also known as a Miller trust, is available in states that offer the special income level option but do not also offer the medically needy option for nursing home care.<sup>14</sup>

The Medicaid program generally bases its characterization of assets— income and resources—for individuals who are 65 years or older or have disabilities on that used by SSI.

- Income is anything received during a calendar month, paid either in cash or in-kind, that is used or could be used to meet food or shelter needs.
- Resources are cash or real or personal property that are owned that can be converted to cash and be used for food or shelter. (See table 1 for examples of different types of assets.)

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<sup>12</sup>Medicaid and CHIP Payment and Access Commission, *Report to Congress, March 2013*.

<sup>13</sup>Money from this irrevocable trust is used to pay for specific costs, such as the applicant's care. Following the individual's death, the state receives all remaining amounts in this trust up to the amount spent by the state for the individual's care.

<sup>14</sup>See 42 U.S.C. § 1396p(d)(4)(B).

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**Table 1: Types of Assets and Examples**

Type of asset	Examples
Income	<ul style="list-style-type: none"><li>• Money earned from work</li><li>• Money generated from resources, such as interest, dividends, and annuity payments<sup>a</sup></li><li>• Money received from other sources, such as Social Security, worker's compensation, and unemployment benefits</li></ul>
Resources	<ul style="list-style-type: none"><li>• Cash</li><li>• Financial and investment resources, such as bank accounts, stocks, and bonds</li><li>• Trusts<sup>b</sup></li><li>• Annuities</li><li>• Real property</li><li>• Vehicles, such as automobiles and boats</li><li>• Life insurance</li><li>• Promissory notes<sup>c</sup></li></ul>

Source: GAO analysis of Supplemental Security Income policy.

<sup>a</sup>Some resources produce income. For example, an annuity is a financial instrument that provides a fixed income over a defined period of time in return for an initial payment of principal. The principal of the annuity is considered a resource, while the payments it generates are considered income.

<sup>b</sup>A trust is an arrangement in which a grantor transfers property to a trustee with the intention that it be held, managed, or administered by the trustee for the benefit of the grantor or certain designated individuals.

<sup>c</sup>A promissory note is a written, unconditional agreement, usually given in return for goods, money loaned, or services rendered, whereby one party promises to pay a certain sum of money at a specified time (or on demand) to another party.

In establishing policy for determining financial eligibility for Medicaid coverage for long-term care, including nursing home care, states can decide, within federal standards, which assets are countable. For example, states may disregard certain types or amounts of income, and may elect not to count certain resources toward financial eligibility.

- Although the resources that are considered not countable varies by state, for the purposes of determining Medicaid eligibility for long-term care, they generally include an individual's primary residence (typically if the individual expresses the intent to return home), an automobile, household goods and personal effects, burial spaces, burial arrangements up to a certain value, and certain types of life insurance.
- While an individual's primary residence is generally not a countable resource for determining Medicaid eligibility, federal law specifies that an individual with substantial equity interest in his or her home is to be excluded from eligibility for Medicaid payment for long-term care; the

amount of allowable equity interest is established by each state within federal guidelines. For 2014, these guidelines specified that state established allowable equity interest amounts could range from \$543,000 to \$814,000.<sup>15</sup>

In most states, to be financially eligible for Medicaid coverage for long-term care, including nursing home care, individuals must have \$2,000 or less in countable resources (\$3,000 for a married couple). However, specific income and resource standards vary depending on the way an individual becomes eligible for Medicaid. (See table 2.) Eligible individuals generally must contribute a portion of their income toward the costs of nursing home care but are allowed to retain a small personal needs allowance, which varies by state but must be at least \$30 per month, to pay for the individual’s clothing and other personal needs.

**Table 2: Income and Resource Standards for Selected Ways of Becoming Eligible for Medicaid Coverage, as of 2014**

Ways of becoming eligible for Medicaid	Income standard	Resource standard
<b>Mandatory coverage</b>		
Supplemental Security Income (SSI) <sup>a</sup>	Less than \$721 per month for an individual and less than \$1,082 per month for a couple	Countable resources of less than \$2,000 for an individual, and less than \$3,000 for a couple
<b>State-elected coverage (optional)</b>		
Medically needy	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard usually no lower than countable resources of less than \$2,000 for an individual or \$3,000 for a couple
Special income level for residents of a nursing facility or institution	State-set income standard no higher than 300 percent of the SSI standard (\$2,163 per month) for an individual <sup>b</sup>	Same as SSI

Sources: GAO analysis of Medicaid eligibility requirements.

<sup>a</sup>Not all SSI recipients automatically qualify for Medicaid. Under Section 1902(f) of the Social Security Act, a state may use more restrictive Medicaid eligibility standards than SSI’s standards, provided the standards are no more restrictive than those the state had in place as of January 1, 1972. As of March 2013, 11 states had opted to use these standards. These states are often referred to as 209(b) states because the origin of this provision was § 209(b) of the Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329, 1381.

<sup>b</sup>Some states also allow applicants to place income in excess of the special income level into a qualified income trust and receive Medicaid coverage for their care. This type of trust, also known as a Miller trust, is available in states that offer the special income level option but do not also offer the medically needy option for nursing home care.

<sup>15</sup>An individual with substantial home equity is not excluded from eligibility for Medicaid payment for long-term care if a spouse, child under age 21, or child who is considered blind or disabled lives in the home. 42 U.S.C. § 1396p(f)(2).

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## Spousal Impoverishment Protections

Federal law requires states to use specific minimum and maximum income and resource standards in determining Medicaid eligibility for married applicants when one spouse is in an institution (referred to as the institutionalized spouse), such as a nursing home, and the other remains in the community (referred to as the community spouse).<sup>16</sup> These provisions enable the institutionalized spouse to become eligible for Medicaid, while leaving the community spouse with sufficient assets to avoid impoverishment.

- **Resources.** The resources of both the institutionalized spouse and the community spouse are considered when determining initial financial eligibility for Medicaid coverage for nursing home care. The community spouse may retain an amount equal to one-half of the couple's combined countable resources, up to the state-specified maximum resource level. States' maximum resource levels cannot exceed the maximum federal standard, which was \$117,240 for 2014.<sup>17</sup> The amount that the community spouse is allowed to retain is generally referred to as the community spouse resource allowance.<sup>18</sup>
- **Income.** A community spouse's income is not considered when determining financial eligibility for Medicaid coverage for nursing home care; the community spouse is allowed to retain all of his or her own income. States establish, within federal standards, a minimum amount of income—a minimum needs allowance—that a community spouse is entitled to retain.<sup>19</sup> If the community spouse's income is less than the minimum needs allowance, then income from the institutionalized spouse can be transferred to the community spouse

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<sup>16</sup>42 U.S.C. § 1396r-5.

<sup>17</sup>If one-half of a couple's combined countable resources is less than a state-specified minimum resource level, then the community spouse may retain resources up to the minimum level. States' minimum resource levels cannot be less than the federal minimum resource standard, which was \$23,448 for 2014.

<sup>18</sup>We use community spouse resource allowance to refer to the amount of a couple's combined jointly and separately-owned resources allocated to the community spouse and considered unavailable to the institutionalized spouse when determining his or her eligibility for Medicaid.

<sup>19</sup>The Social Security Act terms this the minimum monthly maintenance needs allowance. Throughout this report, we refer to this as the minimum needs allowance.

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to make up the difference.<sup>20</sup> As of January 1, 2014, federal standards specified that most states' minimum needs allowance can be no lower than \$1,938.75, and no higher than \$2,931.00 per month.<sup>21</sup>

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## Transfers of Assets

Federal law limits Medicaid payment for long-term care services, including nursing home care, for individuals who divest themselves of—or “transfer”—their assets for less than FMV within a specified time period.<sup>22</sup> As a result, when an individual applies for Medicaid coverage for long-term care, states conduct a review, or “look-back,” to determine whether the applicant (or his or her spouse, if married) transferred assets to another person or party. Per the DRA, the look-back period for transfers made on or after February 8, 2006, is 60 months; prior to the DRA, the look-back period was generally 36 months. If the state determines that an applicant transferred an asset for less than FMV during the look-back period, the individual may be ineligible for Medicaid coverage for long-term care for a period of time, called the penalty period.<sup>23</sup> The penalty period generally begins on the later of (1) the first day of a month during or after an individual transfers assets for less than FMV, or (2) the date on which the individual would otherwise be eligible to receive coverage for services were it not for the penalty period.

Federal law exempts certain transfers made during the look-back period from the penalty provisions. Exemptions include certain transfers of

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<sup>20</sup>If the institutionalized spouse's income is not sufficient to make up the difference, then the community spouse would be allowed to keep resources above the community spouse resource allowance, so that the additional resources could be used to generate more income.

<sup>21</sup>Per federal standards, as of January 1, 2014, the minimum needs allowance for Alaska must be at least \$2,422.50 and for Hawaii must be at least \$2,231.25.

<sup>22</sup>Federal law requires states to apply the transfer of asset provisions to institutionalized individuals, who are defined in the Social Security Act as individuals who are inpatients in a nursing facility or in a medical institution that is being paid based on a level of care received in a nursing home, or certain recipients of home and community-based services. 42 U.S.C. § 1396p(h)(3). States have the option to apply such provisions to noninstitutionalized individuals.

<sup>23</sup>The length of the penalty period, in months, is calculated by dividing the total cumulative amount of assets transferred for less than FMV by the average monthly private pay rate for nursing home care in the state (or the community in which the applicant is institutionalized, at the option of the state).

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assets to a spouse or a disabled child, among other things.<sup>24</sup> A transfer does not result in a penalty period if the individual can demonstrate to the state that the transfer was made exclusively for purposes other than qualifying for Medicaid.<sup>25</sup> Additionally, a penalty would not be applied if the state determined that application of the penalty would result in an undue hardship; that is, it would deprive the individual of (1) medical care such that the individual's health or life would be endangered, or (2) food, clothing, shelter, or other necessities for life.

The DRA also specified circumstances under which the purchase of certain assets—such as an annuity, promissory note, or loan—is considered a transfer for less than FMV for purposes of determining Medicaid eligibility. (See table 3 for a summary of these selected DRA provisions.) Most, but not all, of these provisions became applicable on the date of the DRA's enactment, February 8, 2006.

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<sup>24</sup>Additional exemptions from the penalty period include transfers of assets to an individual for the spouse's sole benefit or to a trust for a disabled child's sole benefit. Transfers of a home are also exempt if made to an individual's spouse, or minor or disabled child; an adult child residing in the home who has been caring for the individual for a specified time period; or a sibling who has an equity interest in the home and has resided in the individual's home for at least 1 year immediately prior to the date the individual became institutionalized. 42 U.S.C. § 1396p(c)(2)(A)-(c)(2)(B).

<sup>25</sup>Transfers also do not result in a penalty when the individual can show that he or she intended to dispose of the assets at FMV or for other valuable consideration, or that all assets transferred for less than FMV have been returned to the individual. 42 U.S.C. § 1396p(c)(2)(C).

**Table 3: Summary of Selected Provisions Regarding Transfers of Assets in the Deficit Reduction Act of 2005 (DRA)**

DRA provision	Description
Annuities <sup>a</sup>	<ul style="list-style-type: none"> <li>States are required to treat the purchase of an annuity as a transfer for less than fair market value (FMV) unless the annuity names the state as either (1) the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant, or (2) a remainder beneficiary in the second position after the community spouse, or minor or disabled child (or in the first position if any of those individuals transfer the remainder of the annuity for less than FMV).</li> <li>Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care shall be treated as a transfer of assets for less than FMV unless the annuity is irrevocable, nonassignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.</li> <li>Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care services that are defined as individual retirement accounts under federal tax code, or purchased with the proceeds of certain retirement accounts and meet certain federal tax code requirements are not considered transfers for less than FMV.</li> </ul>
Life estates	States are required to consider a purchase of a life estate interest in another person's home as a transfer of assets for less than FMV unless the purchaser lived in the home for at least 1 year after the date of purchase.
Promissory notes and loans	States are required to consider funds used to purchase a promissory note, loan, or mortgage as a transfer of assets for less than FMV unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan with no deferral or balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

Source: GAO analysis of the DRA.

<sup>a</sup>The DRA also specified that applications for Medicaid coverage for long-term care shall: (1) describe any interest an applicant or community spouse may have in an annuity, regardless of whether the annuity is irrevocable or treated as an asset; and (2) include a statement that the state becomes a remainder beneficiary of an annuity purchased on or after enactment by virtue of the applicant's receipt of Medicaid assistance for long-term care.

### States' Determination of Applicants' Financial Eligibility

To assess applicants' financial eligibility for Medicaid coverage for long-term care, including nursing home care, and to determine whether they transferred assets for less than FMV, states generally require applicants to submit applications and to provide documentation of certain assets reported on the applications. Our prior work has shown that states varied in the amount of documentation required from applicants; for example, 17 states required all applicants to provide 60 months of documentation of financial and investment resources, while 27 states required applicants to provide just the current month's documentation. We also previously found that all state Medicaid programs obtained some amount of asset information from third parties, such as financial institutions or other

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government agencies, such as the Social Security Administration.<sup>26</sup> Such information helps states verify the accuracy of applicants' reported assets, and to determine if applicants have assets they failed to report or transferred for less than FMV during the look-back period. The processing of Medicaid applications—including the collection of documentation and information from applicants and third parties—is generally performed by local or county-based eligibility workers.

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### Files Reviewed Showed 41 Percent of Approved Applicants Had Total Resources at or below \$2,500, and 5 Percent Transferred Assets

Forty-one percent of the 294 approved applicants whose Medicaid nursing home application files we reviewed had total resources—both countable and not countable resources—of \$2,500 or less; and nearly 75 percent of the approved applicants owned at least some resources that were not countable in their financial eligibility determination. Almost two-thirds of approved applicants had annual gross incomes of \$20,000 or less, and 5 percent were found to have transferred assets for less than FMV.

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### Forty-One Percent of Approved Applicants Reviewed Had Total Resources of \$2,500 or Less; Nearly Three-Quarters Had Some Resources Not Countable for Eligibility Determination

Of the 294 approved Medicaid nursing home applicants whose files we reviewed in selected counties in three states, 41 percent—121 applicants—had total resources of \$2,500 or less. Total resources included both resources that were countable and those that were not countable as part of applicants' Medicaid financial eligibility determination and, for married applicants, resources of both the applicant and the spouse. Another 44 percent of approved applicants—129 applicants—had between \$2,501 and \$100,000 in total resources, and 14 percent of approved applicants—42 applicants—had over \$100,000 in total resources.<sup>27</sup> Median total resources for all approved applicants was

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<sup>26</sup>For additional information on the extent to which states require individuals applying for Medicaid coverage for long-term care to document assets and obtain information about these applicants' assets from third parties, see [GAO-12-749](#).

<sup>27</sup>For two approved applicants who owned at least one resource, there was no information available on the value of any of their resources. As such, the percentages presented do not add up to 100 percent.

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\$7,660,<sup>28</sup> which was less than the median net worth of elderly households in the United States.<sup>29</sup> Married applicants, who made up 24 percent of the approved applicants, had higher median resources (\$70,137) than single applicants (\$3,034).<sup>30</sup> (See fig. 1.)

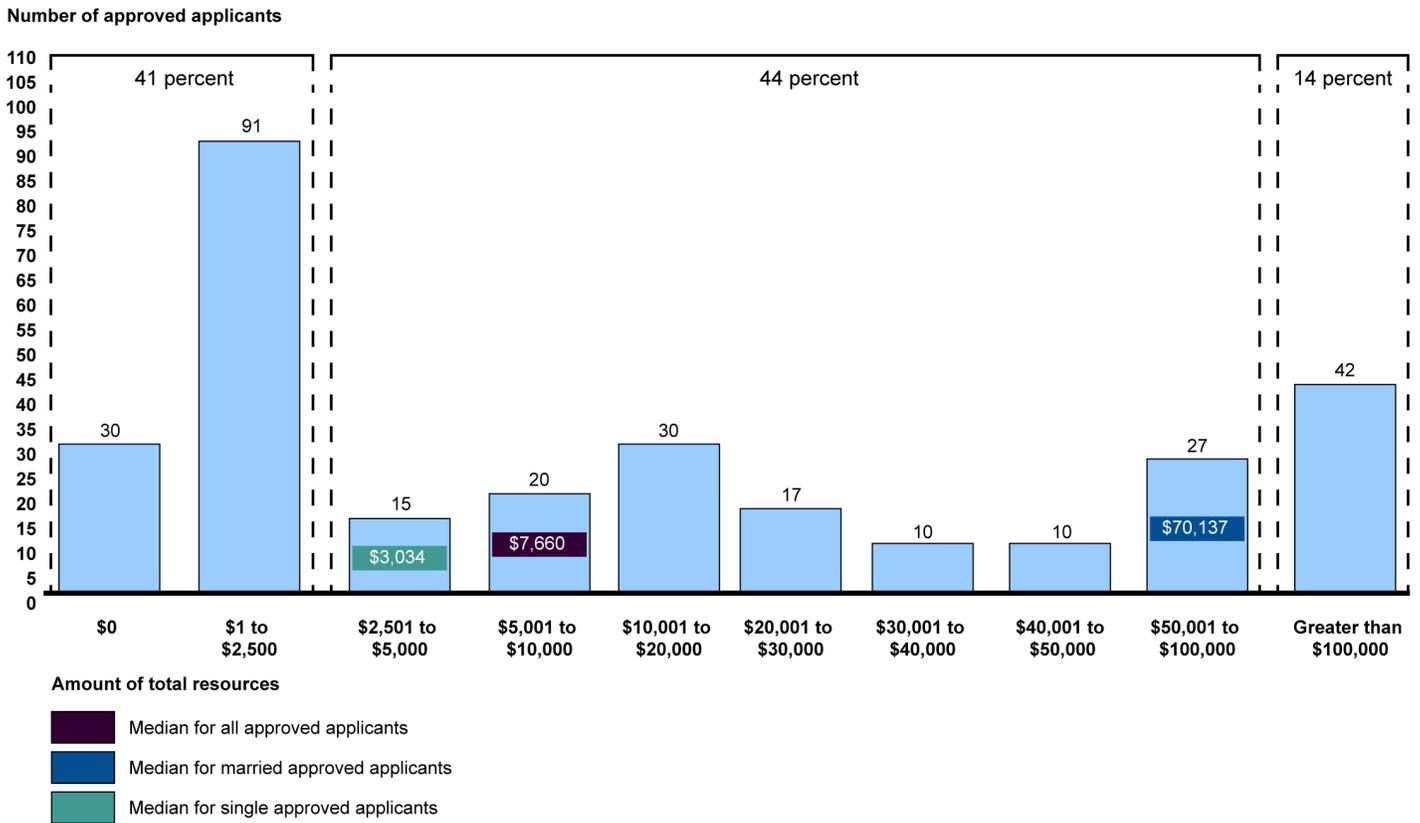
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<sup>28</sup>Total resources of approved applicants averaged \$60,375 and ranged from \$0 to \$1,551,344.

<sup>29</sup>The median net worth of elderly households in the United States was \$170,516 in 2011. Net worth is defined as the total value of all of the resources that an individual or household owns, including the value of real estate, stocks, bonds, retirement accounts, and other resources, minus debts or liabilities. Elderly households are those with a householder aged 65 or older; the householder is the person in whose name the home is owned or rented. See U.S. Census Bureau, *Survey of Income and Program Participation, 2008 Panel, Wave 10*, accessed March 28, 2014, [http://www.census.gov/people/wealth/files/Wealth\\_Tables\\_2011.xlsx](http://www.census.gov/people/wealth/files/Wealth_Tables_2011.xlsx).

<sup>30</sup>Total resources for approved applicants who were married averaged \$169,968 and ranged from \$0 to \$1,551,344; for single applicants, total resources averaged \$25,822 and ranged from \$0 to \$460,147.

**Figure 1: Distribution of Approved Applicants in Selected Counties in Three States by Amount of Total Resources (n=294)**



Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

Consistent with how Medicaid eligibility is determined for coverage of nursing home care, our analysis of total resources for married applicants includes those of both the spouse and the applicant.

For 2 of the 294 approved applicants who owned at least one resource, there was no information available on the value of any of their resources. As such, the percentages shown do not add to 100. Files for the remaining applicants included information on the value of at least one resource; all known values were summed to determine the total resources per applicant. However, if an applicant's file did not contain a value for every resource the applicant owned, then the amount of their total resources may be underestimated.

Approved applicants most commonly owned the following types of resources: financial and investment resources (95 percent), burial contracts and prepaid funeral arrangements (39 percent), life insurance policies (34 percent), their primary residence (31 percent), and vehicles (26 percent). With the exception of the applicant's primary residence, the median value of these more commonly owned resources was less than

that of other resources—namely annuities, life estates, promissory notes, or trusts—that were less commonly owned. (See table 4.)

**Table 4: Number of Approved Applicants in Selected Counties in Three States that Owned Resources, and the Value of Resources Owned, by Type of Resource**

Resource	Number (percent) of approved applicants who owned resource	Number of applicants for whom the value of resource owned was known <sup>a</sup>	Median value of resource
Financial and investment <sup>b</sup>	278 (95%)	277	\$1,200
Burial contracts and prepaid funeral arrangements	114 (39%)	95	\$9,311
Life insurance	101 (34%)	86	\$2,422
Primary residence	91 (31%)	66	\$68,350
Vehicle	77 (26%)	51	\$3,110
Life estate	10 (3%)	4	\$71,550
Real property other than primary residence	10 (3%)	10	\$47,300
Trust	9 (3%)	4	\$82,000
Promissory note or loan	5 (2%)	5	\$116,500
Annuity	3 (1%)	2	\$44,261
Other resources <sup>c</sup>	6 (2%)	3	\$1,361

Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

Consistent with how Medicaid eligibility is determined for coverage of nursing home care, resources for married applicants include those of both the spouse and the applicant.

<sup>a</sup>The value of a resource was considered to be known if the applicant's file included information on the value for at least one of that type of resource. For example, if an applicant had two bank accounts, the value of financial and investment resources was considered to be known if the applicant's file included information on the value of at least one of the accounts. Missing values may have affected the median values of each type of resource.

<sup>b</sup>Financial and investment resources includes such items as checking or savings bank accounts, stocks, bonds, and retirement accounts.

<sup>c</sup>Other resources include such items as cash, livestock, and unspecified property in safety deposit boxes or storage units.

Certain types of resources, such as prepaid burial arrangements, are generally not countable for purposes of determining Medicaid eligibility. Of the approved applicants whose files we reviewed, 74 percent (218 of 294) owned at least some resources that were not countable as part of their financial eligibility determination, though the amount of noncountable resources owned varied. Files for 195 of these 218 applicants contained

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information on the value of at least one noncountable resource owned.<sup>31</sup> Among these 195 applicants, 55 percent (108 applicants) had \$20,000 or less in noncountable resources, 27 percent (53 applicants) had noncountable resources between \$20,001 and \$100,000, and 17 percent (34 applicants) had greater than \$100,000 in resources that were not countable toward eligibility. The median value of noncountable resources was \$12,530.<sup>32</sup> Approved applicants who were married had a greater median value of noncountable resources (\$60,651) than single applicants (\$9,931), which could be due, in part, to Medicaid eligibility rules that include provisions intended to protect the community spouse from impoverishment.<sup>33</sup> (See fig. 2.)

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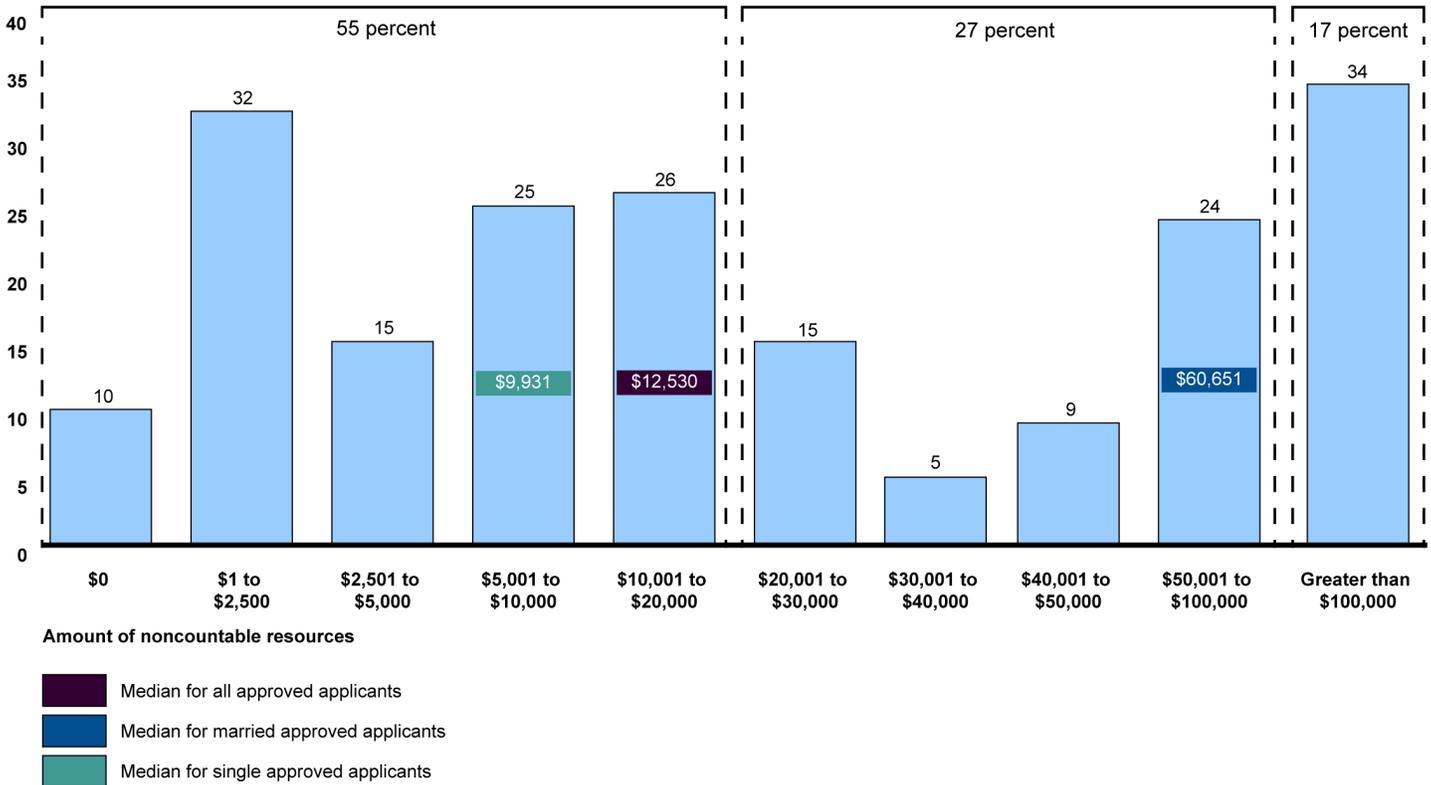
<sup>31</sup>Twenty-three approved applicants whose files we reviewed owned at least one noncountable resource but there was no information available on the value of any of the noncountable resources that they owned.

<sup>32</sup>Noncountable resources for approved applicants averaged \$80,427 and ranged from \$0 to \$1,541,565.

<sup>33</sup>Noncountable resources for approved applicants who were married averaged \$180,594 and ranged from \$12 to \$1,541,565; for single applicants, noncountable resources averaged \$36,972 and ranged from \$0 to \$446,166.

**Figure 2: Distribution of Approved Applicants in Selected Counties in Three States by Amount of Noncountable Resources (n=195)**

Number of approved applicants



Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

Within federal standards, states may elect not to count certain resources toward financial eligibility. Thus, the amount of noncountable resources reflects the value of the applicant's resources that the state elected not to count during eligibility determination. Consistent with how Medicaid eligibility is determined for coverage of nursing home care, noncountable resources for married applicants include those of both the spouse and the applicant.

Of the 294 approved applicants whose files we reviewed, 218 owned at least one noncountable resource. For 23 of these 218 approved applicants, there was no information available on the value of their noncountable resources. Files for the remaining 195 applicants included information on the value of at least one noncountable resource; all known values were summed to determine the amount of noncountable resources per applicant. However, if an applicant's file did not contain a value for every noncountable resource the applicant owned, then the amount of their noncountable resources may be underestimated.

Percentages shown do not add to 100 due to rounding.

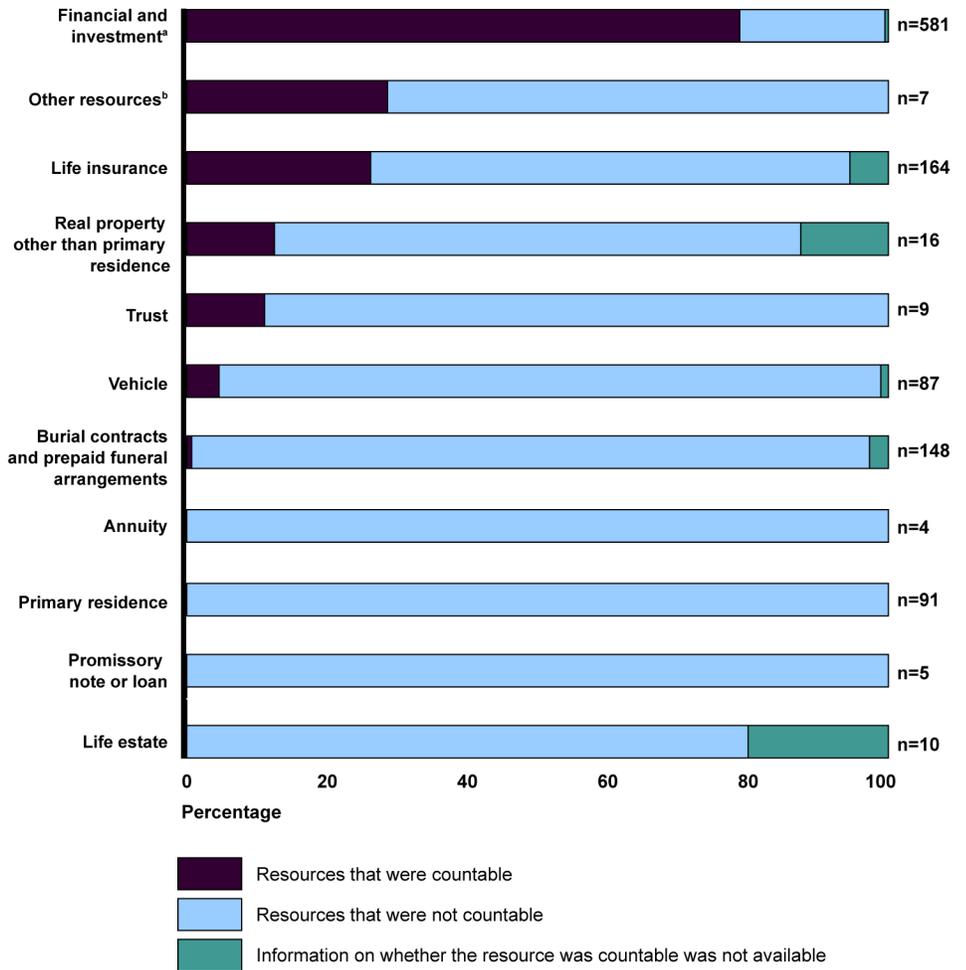
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The extent to which the types of resources applicants owned were countable toward applicants' eligibility varied. While 79 percent of the financial and investment resources owned by approved applicants were countable, the majority of vehicles, and burial contracts and prepaid funeral arrangements were not countable as part of eligibility determination. Additionally, none of the applicants' annuities, promissory notes, or primary residences were countable. (See fig. 3.) Although an applicant's primary residence is typically not a countable resource, an applicant with significant equity interest in his or her home is not eligible for Medicaid payments for nursing home care.<sup>34</sup> For the 51 applicants for whom we were able to determine the equity interest in the home, the median home equity was \$50,000, and ranged from \$0 to \$700,000.

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<sup>34</sup>The amount of allowable home equity interest is established by each state within federal guidelines and could range from \$543,000 to \$814,000 in 2014. However, an individual with home equity greater than the state's allowable amount is not excluded from eligibility if a spouse, child under age 21, or child who is blind or disabled lives in the home.

**Figure 3: Proportion of Resources that Were Countable as Part of Applicants' Financial Eligibility Among Approved Applicants in Selected Counties in Three States, by Type of Resource**



Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

<sup>a</sup>Financial and investment resources includes such items as checking or savings bank accounts, stocks, bonds, and retirement accounts.

<sup>b</sup>Other resources include such items as cash, livestock, and unspecified property in safety deposit boxes or storage units.

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Almost Two-Thirds of  
Approved Applicants  
Reviewed Had Income of  
\$20,000 or Less

Sixty-five percent of approved applicants whose files we reviewed—192 applicants—had annual gross incomes of \$20,000 or less, another 30 percent—88 applicants—had annual gross incomes between \$20,001 and \$50,000, and 5 percent—14 applicants—had annual gross incomes greater than \$50,000.<sup>35</sup> The median annual gross income of approved applicants was \$16,260 (\$1,355 per month),<sup>36</sup> which was less than the median annual income of the elderly in the United States.<sup>37</sup> In contrast to resources, the median annual gross income of married approved applicants (\$16,260) was nearly the same as that of their single counterparts (\$16,284); consistent with how Medicaid eligibility is determined, applicants' income includes just that of the applicant, regardless of marital status. (See fig. 4.)

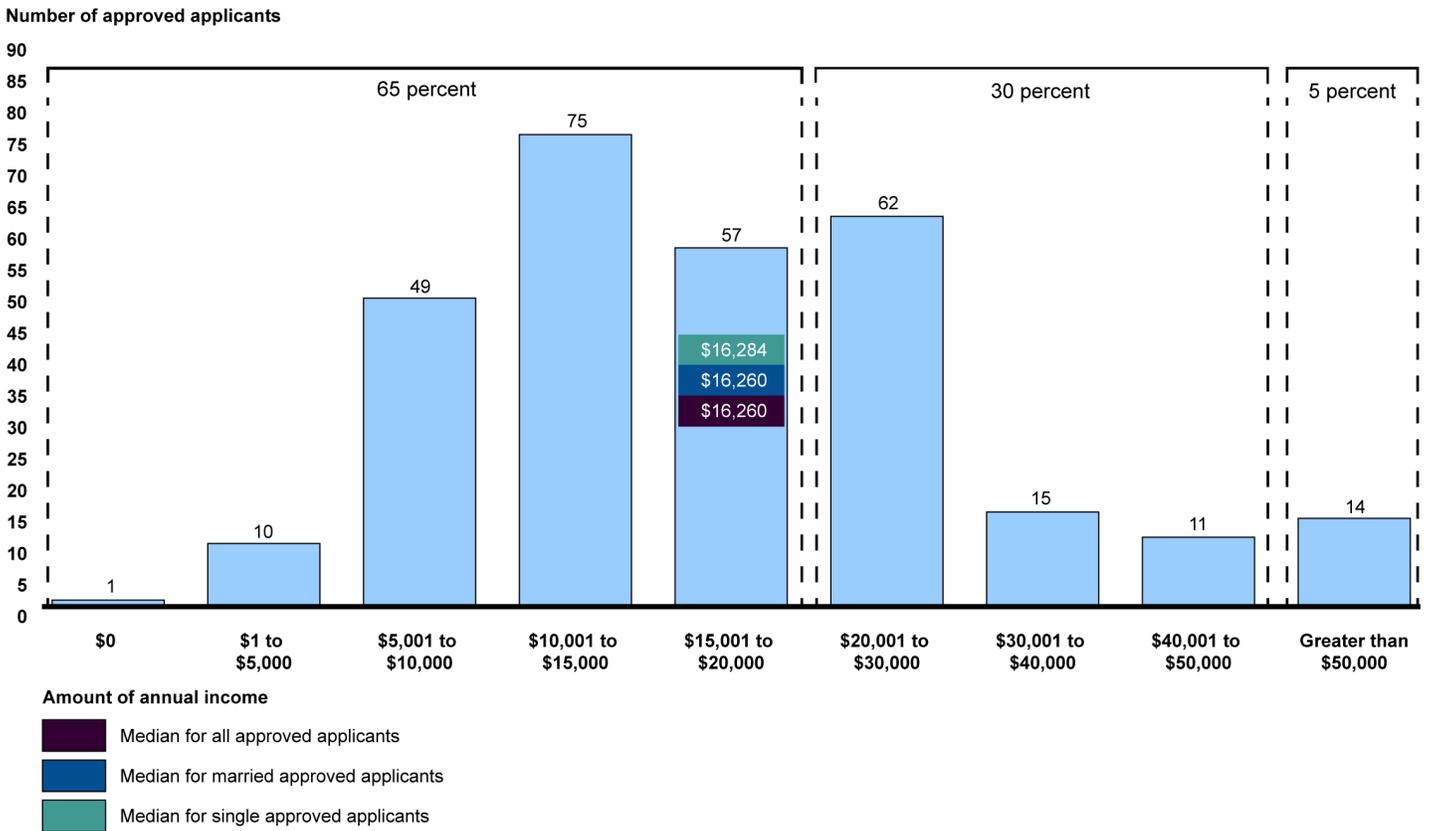
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<sup>35</sup>In Florida and South Carolina, applicants can place income above the special income level for nursing home residents in a qualified income trust, which is used to pay for the applicants' care. New York has a "medically needy" option, whereby applicants can qualify for coverage if their income, after subtracting any medical expenses, is less than or equal to the state's income standard.

<sup>36</sup>Annual gross income for all approved applicants averaged \$20,607 and ranged from \$360 to \$161,064.

<sup>37</sup>The median annual income of the elderly in the United States was \$20,308 (\$2,828 per month) in 2012. See U.S. Census Bureau, *Current Population Survey, 2013 Annual Social and Economic Supplements*, accessed April 1, 2014, [http://www.census.gov/hhes/www/cpstables/032013/perinc/pinc02\\_000.htm](http://www.census.gov/hhes/www/cpstables/032013/perinc/pinc02_000.htm).

**Figure 4: Distribution of Approved Applicants in Selected Counties in Three States by Annual Gross Income**



Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

Consistent with how Medicaid eligibility is determined for coverage of nursing home care, income includes just that of the applicant, regardless of the applicant's marital status.

Social Security was the primary source of income for approved applicants we reviewed, comprising three-quarters of their annual income, on average. Almost all approved applicants—95 percent—received Social Security, and nearly half—45 percent—received income from a retirement account or pension. Few applicants received income from other sources, such as an annuity, trust, or promissory note.

For slightly more than half (33) of the 60 married approved applicants who had a spouse living in the community, the community spouse was allowed to retain at least some of the applicant's income to bring their

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monthly income up to the state's minimum needs allowance. The median value of the amount of the applicant's income that the community spouse was allowed to retain was \$1,102 per month.<sup>38</sup>

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### Files Reviewed Showed Five Percent of Approved Applicants Transferred Assets for Less Than Fair Market Value

Files for 5 percent of approved applicants reviewed—15 applicants—showed transfers of assets for less than FMV during the look-back period; such transfers are to result in the assessment of a penalty period. The median amount of assets transferred was \$24,608, and the amounts ranged from \$5,780 to \$296,221. The majority of applicants identified as transferring assets for less than FMV—14 of the 15 applicants—transferred money. Applicants typically transferred assets to a child or grandchild (9 of the 15 applicants). Thirteen of the 15 applicants found to have transferred assets were not married. All but one of the applicants found to have transferred assets were from New York, the remaining applicant was from South Carolina.<sup>39</sup> Among applicants found to have transferred assets, the median length of the penalty period assessed was nearly 4 months, and the length ranged from half a month to nearly 25 months.

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### Applicants Used Four Main Methods to Reduce Countable Assets and Qualify for Medicaid

We identified four main methods used by applicants—or described by eligibility workers, state officials, attorneys, or other representatives from law practices—to reduce countable assets and qualify for Medicaid coverage for nursing home care. These four methods are: (1) spending countable resources on goods and services that are not countable, (2) converting countable resources into noncountable resources that generate an income stream, (3) giving away countable assets, and (4) increasing the amount of assets the community spouse retains.

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<sup>38</sup>The average amount of approved applicants' income that was provided to the community spouse was \$1,186 per month, and the amount ranged from \$178 to \$3,535 per month. Applicant files for five married applicants did not indicate whether income from the institutionalized spouse was provided to the community spouse.

<sup>39</sup>Applicants in South Carolina and New York were subject to a 60-month look-back period. Florida, however, did not implement the DRA provision to extend the look-back period from 36 months to 60 months until 2010, after which it was phased in over time. As a result, applicants whose files we reviewed in Florida were subject to a 36-month look-back period.

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## Spending Countable Resources on Goods and Services That Are Not Countable Toward Financial Eligibility

One method Medicaid applicants could use to reduce assets is paying off existing debt or making certain purchases. When such purchases and payments convert a countable resource, such as money in the bank, into a good or service that is not countable toward Medicaid financial eligibility, they effectively reduce the applicants' assets. Eligibility workers mentioned possible goods that would not be countable that applicants could purchase.

- Eligibility workers in 10 of the 12 counties interviewed stated that purchasing burial contracts and prepaid funeral arrangements, which are generally noncountable resources, was a common way applicants reduced their countable assets; and eligibility workers from one state said they recommend making such purchases to applicants.
- Eligibility workers also reported that applicants spend down their countable resources on upgrades to their homes, such as a new roof or carpeting.

States may require applicants to provide documentation related to these purchases, such as construction contracts or receipts, to verify that the purchases were not made for less than FMV.

Applicants can also use countable resources to purchase services, which are not considered a resource. For example, applicants may pay for a personal service contract, also referred to as a care agreement, which is an arrangement in which an individual pays another person, often an adult child, to provide certain services—such as grocery shopping or transportation to medical appointments—over a period of time. Although personal service contracts are not considered a resource, payment for the contracts involve a transfer of resources, and thus must be assessed to determine whether the transfer was made for less than FMV. If such contracts are determined to have been made for less than FMV, then the applicant would be subject to a penalty period. According to CMS, states can establish reasonable standards for assessing whether or not a transfer using a personal service contract is made for less than FMV. Our interviews with state Medicaid officials indicate that states' standards for assessing the FMV of personal service contracts vary.

- Some states require that payments under the contract be made at the time the services are rendered; thus, these states would consider a lump sum payment made for services that had been provided sometime in the past or for services that will be provided in the future to be a transfer for less than FMV.

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- In contrast, officials from one state we spoke with indicated that the state does not have standards regarding when payment must be made. Officials from this state reported seeing at least 100 applications each month containing personal service contracts.

#### **Personal Service Contracts**

The files we reviewed included a \$7,055 personal service contract between an applicant and her daughter for the provision of 10 hours of care per week at a rate of \$11 per hour for an estimated 1.2 years. Another applicant had a \$134,316 contract with her son to provide 20 hours of services per week at a rate of \$35 per hour for an estimated 3.7 years. Under both personal service contracts, the provider received one lump sum payment.

Among the Medicaid application files that we reviewed in selected states, 16 of the 294 approved applicants (5 percent) had a personal service contract—all of which were determined to be for FMV. The median value of the personal service contracts was \$37,000; the value of the contracts ranged from \$4,460 to \$250,004.

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### **Converting Countable Resources into Noncountable Resources That Generate an Income Stream for the Applicant**

Applicants may reduce their countable resources by purchasing certain financial instruments that generate an income stream. While the income stream is likely countable, the principal of the financial instrument might not be a countable resource when determining an applicant's financial eligibility. For these purchases to be effective in helping the individual qualify for Medicaid coverage, the income generated would need to be less than the applicant's expenses, including the cost of nursing home care; otherwise the applicant would not likely be income-eligible for Medicaid coverage for nursing home care. Additionally, the principal would need to be a noncountable resource, otherwise the applicant would not likely be resource-eligible for Medicaid coverage.

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### Irrevocable Annuities

In certain circumstances an irrevocable annuity can be considered a countable resource. For example, according to CMS, if the annuity can be sold on the secondary market because its owner or payee may be changed (i.e. the annuity is assignable), then the annuity is a countable resource.

One instrument applicants can purchase to convert countable resources into noncountable resources with an income stream is an irrevocable and nonassignable annuity that complies with the DRA.<sup>40</sup> A representative from one law office that we spoke to in an undercover capacity indicated that an annuity is an option that could allow at least some resources to be left for the applicant's heirs. While the individual noted that the income generated from the annuity must be spent on nursing home care, he explained that the applicant may be able to save some money to leave to his children because the amount the applicant would have to pay toward his nursing home care would be based on the Medicaid nursing home payment rate, which is likely less than what the applicant would have otherwise had to pay privately. Medicaid officials from more than half the states for which we conducted interviews indicated that the use of annuities has increased over the past few years, and officials from one of these states indicated that this increase was a result of clearer guidelines in the DRA on annuities.

Another financial instrument applicants may be able to purchase to convert countable resources into noncountable resources with an income stream is a promissory note, under which applicants lend funds to another party, such as an adult child.<sup>41</sup> States are required to determine whether the funds used to purchase a promissory note were a transfer for less than FMV.<sup>42</sup> Additionally, according to CMS officials, if a promissory note is determined to have been purchased at FMV, states must also determine whether the principal of the note should be treated as a countable resource. Based on our interviews with state Medicaid officials,

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<sup>40</sup>Irrevocable means that the annuity cannot be changed or terminated, and nonassignable means that the annuity cannot be transferred to another individual. As previously noted, the DRA specified that annuities purchased by or on behalf of the individual applying for Medicaid must meet criteria such as being actuarially sound—that is, they must pay out during the applicant's life expectancy; providing payments in equal amounts during the term of the annuity; and naming the state as the primary remainder beneficiary unless there is a community spouse or minor or disabled child. Otherwise, the annuity would be considered a transfer for less than FMV.

<sup>41</sup>A promissory note is a written, unconditional agreement, usually given in return for goods, money loaned, or services rendered, whereby one party promises to pay a certain sum of money at a specified time (or on demand) to another party.

<sup>42</sup>The purchase of a promissory note is to be considered a transfer for less than FMV unless the repayment terms are actuarially sound, it provides for payments to be made in equal amounts during the term of the loan with no deferral or balloon payments, and it prohibits the cancellation of the balance upon the death of the lender. 42 U.S.C. § 1396p(c)(1)(I).

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states' standards for determining whether to treat the principal of promissory notes as a countable resource vary.

- Medicaid officials from one state told us that the principal of promissory notes could be considered a countable resource if it were negotiable.
- Medicaid officials from another state said that the principal would be a countable resource if the note could be converted into cash within 20 days.

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## Giving Away Some or All Countable Assets

Applicants may reduce their countable assets by giving some or all of their assets as a gift to another individual, such as an adult child. Such gifts are typically treated as a transfer for less than FMV and, if given during the look-back period, would likely result in a penalty period. The length of the penalty period is calculated based on the value of the gift and the private payment rate for nursing home services in the state or locality.<sup>43</sup> However, our interviews identified mechanisms that either reduce the length of the penalty period after it has started or provide funds to pay for care during the penalty period. These mechanisms are referred to as “reverse half-a-loaf” because they can be used to preserve at least half of an individual’s resources.<sup>44</sup>

A “reverse half-a-loaf” mechanism that reduces the length of the penalty period involves gifting countable assets to someone else and then, after eligibility has been determined and the penalty period begins, having a portion of the gift returned to the applicant. This option only works in states that choose to consider a partial return of transferred assets in recalculating the penalty period. According to CMS, states can choose whether or not to consider a partial return of transferred assets. In states

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<sup>43</sup>For example, if the applicant transferred \$35,000 worth of assets for less than FMV and the average monthly private pay rate for nursing home care in the state was \$7,000, the penalty period would be 5 months.

<sup>44</sup>As we previously reported, prior to the DRA, individuals used a mechanism commonly referred to as the “half-a-loaf” strategy, which involved transferring a portion (e.g., half) of one’s assets and waiting out a penalty period before applying for Medicaid coverage of nursing home care. However, the DRA changes to the start date of the penalty period eliminated the availability of the “half-a-loaf” strategy. According to state Medicaid officials and attorneys we spoke with, the “reverse half-a-loaf” mechanism has since emerged.

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that consider partial returns, the original length of the penalty period would be shortened in proportion to the amount of assets returned.<sup>45</sup>

Another “reverse half-a-loaf” mechanism involves an applicant gifting a portion of their countable resources, incurring a penalty, and converting other countable resources into an income stream for the applicant—such as through an annuity or promissory note—to pay for nursing home care during the penalty period. The amount of income generated from the annuity or promissory note would be equivalent to the shortfall between the applicant’s other monthly income, such as Social Security and retirement income, and the cost of his/her nursing home care during the penalty period. A representative from one law office we spoke to in an undercover capacity suggested that the applicant could gift about 50 percent of her resources, and while serving a penalty period, the applicant would use monthly income from a promissory note plus other monthly income to pay for the nursing home care. Another representative from a law office mentioned that the larger the applicant’s income, the larger the amount that the applicant can gift. This is because an applicant with higher income would need less additional income from an annuity or promissory note to cover the costs of nursing home services during the penalty period. Thus, an applicant with higher income would need to place a smaller amount of their countable resources into an annuity or promissory note, allowing them to gift more of their countable resources even if it may result in a longer penalty period.

#### **Reverse Half-a-Loaf**

One applicant who appeared to use the “reverse half-a-loaf” mechanism gifted \$62,470 to his children and was assessed a 6 month penalty period. This applicant also loaned \$63,118 to one of his children in return for a promissory note that provided \$10,543 in income per month during the 6 months of the applicant’s penalty period.

Among the 294 approved applicants whose files we reviewed, we identified 5 applicants (2 percent) who appeared to have used one of the “reverse half-a-loaf” mechanisms; 4 of the applicants appeared to use the mechanism that involved creating an income stream through a promissory note to pay for nursing home care during the penalty period. These 4 applicants gifted between \$20,150 and \$227,250 worth of resources, and had penalty periods of between 2 months and 22 months.

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<sup>45</sup>If all of the transferred assets are returned, then the penalty period is eliminated. However, the returned assets will likely be considered countable assets for purposes of determining the individual's Medicaid eligibility.

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## Increasing the Amount of Assets the Community Spouse Retains

An additional method married applicants could use to reduce countable assets is to increase the amount of assets that the community spouse is able to retain. Given the federal law regarding the treatment of the community spouse's resources and provisions intended to protect married individuals, there are several different mechanisms for increasing the assets retained by the community spouse.

## Spousal Refusal

Federal law permits the community spouse to retain an amount equal to one-half of the couple's combined countable resources, up to the state-specified maximum resource level. However, our work identified a mechanism that could result in a community spouse retaining more than the maximum standard in instances where the state did not exercise its right to sue the community spouse to recoup the resources due to the institutionalized spouse. Under this mechanism, an institutionalized spouse may transfer all his or her resources to the community spouse, while assigning to the state the right to bring a support proceeding against the community spouse.<sup>46</sup> In this way, a community spouse who refuses to make any resources available to the institutionalized spouse may be able to retain all of the couple's resources unless the state chooses to sue the community spouse for support.<sup>47</sup> According to information from state officials, some states take legal action to recoup funds from the community spouse in cases of spousal refusal, while other states do not.

- Medicaid officials from one state told us that they do not see many applications claiming spousal refusal, adding this is likely because the state would take legal action against the community spouse to recoup expenses.
- Officials from other states told us that, in cases of spousal refusal, they do not take action against the community spouse.

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<sup>46</sup>Generally, when an applicant assigns his or her support rights to a state, the state supports and pays for the medical care of the applicant. In exchange, the applicant agrees to cooperate in providing information and assisting the state in pursuing support from the community spouse.

<sup>47</sup>Under federal law, an institutionalized spouse cannot be considered financially ineligible due to excess resources if one of the following three conditions are met: (1) the institutionalized spouse has assigned to the state their rights to support from the community spouse; (2) the institutionalized spouse lacks the ability to execute an assignment of support rights due to physical or mental impairment, but the state has the right to sue the community spouse for support without such assignment; or (3) the state has determined that denial of eligibility would result in an undue hardship to the institutionalized spouse. 42 U.S.C. § 1396r-5(c)(3).

Of the 70 married approved applicants whose files we reviewed, 13 had applications that contained a claim of spousal refusal. (See table 5.) These 13 applicants resided in two states and the community spouse retained a median value of \$291,888 in nonhousing resources; two of the community spouses were able to retain over \$1 million in nonhousing resources.<sup>48</sup> Six of the 13 applicants also provided monthly income support to their community spouse.<sup>49</sup>

**Table 5: Amount of Nonhousing Resources and Monthly Income Support Retained by the Community Spouse in Cases of Spousal Refusal, for Approved Applicants in Selected Counties in Three States**

Applicant	Amount of nonhousing resources retained by the community spouse	Amount of monthly income provided by the institutionalized spouse to the community spouse
1	\$13,306	\$0
2	\$47,214	\$1,874
3	\$126,627	\$441
4	\$146,862	\$0
5	\$194,912	\$0
6	\$212,611	\$0
7	\$291,888	\$770
8	\$352,936	\$0
9	\$394,189	\$1,734
10	\$432,860	\$0
11	\$452,251	\$1,588
12	\$1,429,209	\$2,088
13	\$1,585,467	\$0

Source: GAO analysis of Medicaid application data.

Note: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

<sup>48</sup>The average amount of nonhousing resources the community spouse retained was \$436,949, and ranged from \$13,306 to \$1,585,467. According the federal standards, the maximum amount of countable resources that a community spouse can retain is \$117,240 in 2014. That amount was \$113,640 in 2012.

<sup>49</sup>The amount of monthly income support provided to the community spouse averaged \$1,416 and ranged from \$441 to \$2,088.

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## Annuities for the Community Spouse

Married applicants may reduce their countable assets by purchasing an irrevocable and nonassignable annuity that pays out income to the community spouse. Although annuities for the community spouse must be actuarially sound—that is, they must pay out during the community spouse’s life expectancy—and must name the state as a remainder beneficiary, there are no other limitations on the time period in which annuities must pay out. Additionally, there is no limit on the amount of income from the annuity, as the community spouse’s income is not countable as part of the institutionalized spouse’s eligibility. While any portion of the income from the annuity that is not spent in the month it is received becomes a resource, a community spouse’s resources are generally not assessed again after his or her spouse is initially deemed eligible, and thus would not affect the institutionalized spouse’s eligibility.<sup>50</sup>

### Annuities for the Community Spouse

State Medicaid officials, county eligibility workers, and attorneys who provided information on the value of annuities for the community spouse reported average values ranging from \$50,000 to \$300,000. Officials from one state reported seeing annuities for the community spouse worth more than \$1 million. Medicaid officials from one state indicated that they have seen annuities that disbursed all of the payments to the community spouse shortly after the annuity was purchased, while officials from another state said that annuities can have large monthly payments for the community spouse, such as \$10,000 per month.

Thus, married applicants may use countable resources to purchase an irrevocable annuity that pays potentially large amounts of income for the community spouse over a short period of time without affecting the institutionalized spouse’s eligibility. A representative from one law office we spoke to in an undercover capacity suggested that the creation of an annuity can be done quickly and therefore, is a tool for last minute planning. Similar to the annuities for the applicant, Medicaid officials from several states said that the use of annuities for the community spouse has increased over the past few years. Officials from three states said that the increase may be a result of the passage of the DRA, because it clarified how annuities for the community spouse could be set up.

## Court Order of Support

Married applicants may seek a court order that requires the institutionalized spouse to pay a specified monthly income or provide additional resources to support the community spouse. Such court orders could allow the community spouse to receive income or resources in excess of maximum standards. Federal law requires that a community spouse’s income allowance be no less than the amount of the court order of support.<sup>51</sup>

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<sup>50</sup>Per federal law, a month after eligibility is determined, and during the continuous period in which the institutionalized spouse remains in an institution, the community spouse’s resources are deemed unavailable and thus not countable. 42 U.S.C § 1396r-5(c)(4).

<sup>51</sup>42 U.S.C. § 1396r-5(d)(4).

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One state Medicaid official that we spoke to said that applicants who use court orders will have a preeligibility asset test, or needs assessment, conducted to determine the amount of excess resources that the married couple would have to spend down before applying for Medicaid, after which they will seek a court order of resource support that allows the spouse to keep an amount of the couple's combined resources that is above the state's maximum resource allowance. Of the 70 married approved applicants whose files we reviewed, 1 applicant had a court order of spousal income support that required the institutionalized applicant to divert \$5,014 of her monthly income to the community spouse, which was greater than the state's minimum needs allowance.

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## Eligibility Workers Considered Bank Statements the Most Useful Source to Identify and Verify Applicants' Financial Eligibility

Eligibility workers from all 12 counties in which we conducted interviews stated that bank statements were the most useful source of information for identifying and verifying applicants' financial eligibility. According to the eligibility workers we spoke with, bank statements show transactions, such as payments of life insurance premiums, the movement of lump sums of money over time, or transfers of money in and out of accounts. Presumably, these workers had access to itemized bank statements—periodic statements issued by a financial institution to its customers detailing all account activity for that period. Eligibility workers from one county said that bank statements allowed them to best understand an applicant's financial history. Additionally, bank statements can include red flags or triggers that can lead eligibility workers to ask the applicant for additional information.

- For example, eligibility workers from counties in which we conducted interviews indicated that large withdrawals or patterns of withdrawals, incomplete documentation (e.g., missing pages), or an applicant having a large number of accounts can prompt further inquiry.
- Eligibility workers also reported that reviews of bank statements could lead to the identification of unreported assets or accounts. The most commonly unreported asset those eligibility workers reported finding in bank statements were life insurance policies. Specifically, eligibility workers from 7 of the 12 counties in which we conducted interviews reported that life insurance policies are commonly not reported and may be found while reviewing itemized bank statements because the statements may show a payment for the life insurance premium. Life insurance policies that have a cash value could affect an applicant's eligibility.

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Although eligibility workers indicated that bank statements are the most useful source of information on applicants' assets, we have previously found that over half of states require only a single month's documentation for financial and investment resources, such as bank accounts.<sup>52</sup> Having only a single month's bank statement could be sufficient to determine the current value of an applicant's account, but it may not allow eligibility workers to identify patterns of withdrawals over time which could indicate the need for additional review. All the eligibility workers we interviewed, however, said they ask for additional information if they see large withdrawals in the bank statements that were submitted. For example, eligibility workers from one county that requires only a single month of documentation said if there is questionable information in the documentation they will request that the applicant submit additional months of documentation. Additionally, we previously found that few states require applicants to provide itemized bank statements as documentation of their resources.<sup>53</sup> While applicants may submit itemized bank statements even if not required, without such detailed statements, eligibility workers may not be able to discover unreported assets, such as life insurance policies.

Some eligibility workers we interviewed indicated that applicants' income tax returns were also a helpful source of information to identify applicants' unreported assets. Specifically, eligibility workers from three counties (in two states) told us that they ask applicants for a copy of their federal tax return. For example, eligibility workers from one county stated that they require applicants to provide 5 years of tax returns. These workers indicated that income tax returns include much information that workers would otherwise not be able to access, such as information about ownership of life insurance policies, stocks, or any other asset that earns dividends. In our previous work, we found that only one state requires the submission of income tax returns.<sup>54</sup>

In addition to bank statements and tax returns, eligibility workers also reported finding some asset-related search tools helpful in identifying and verifying applicants' assets and transfers. Workers from one county in Florida that had recently begun piloting an electronic asset verification

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<sup>52</sup>[GAO-12-749](#).

<sup>53</sup>[GAO-12-749](#).

<sup>54</sup>[GAO-12-749](#).

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system (AVS)<sup>55</sup>—a system that allows workers to contact multiple financial institutions to determine if an applicant has, or had, an account and the value of any existing accounts—noted that this new system has been useful in identifying unreported assets and transfers.<sup>56</sup> The state’s AVS collects information from participating banks on any accounts held by an applicant for nursing home coverage in the prior 60 months. If a bank account is found, the information is populated into the state’s electronic eligibility system for eligibility workers to use in evaluating applicants’ financial eligibility. Officials from Florida told us that their AVS is connected to the vast majority of banks operating in their state. Although all states were required to have an electronic AVS in place by the end of fiscal year 2013,<sup>57</sup> only 2 of the 12 states for which we conducted interviews reported having implemented an AVS. In our prior work, we found that states identified challenges to implementing an AVS, including a lack of resources—money, staff, or time—to implement the system, and challenges getting financial institutions to participate.<sup>58</sup>

Eligibility workers from one county reported using certain commercial investigative software that pulls together publically available information nationwide to help verify or identify applicants’ assets or transfers. This software can help eligibility workers find information on unreported assets and transfers, such as information about property deeds or ownership of a business. The workers reported that this software is used in cases where the eligibility worker suspects the applicant owns, for example, an out-of-state unreported asset. In this county, only the two eligibility worker supervisors and investigative staff have access to this software.

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<sup>55</sup>In 2008, Congress passed legislation that required states to implement electronic AVS to verify the assets of aged, blind, or disabled applicants for Medicaid, including those seeking Medicaid coverage for long-term care, with financial institutions. Supplemental Appropriations Act, 2008, Pub. L. No. 110-252, § 7001(d)(1), 122 Stat. 2323, 2391 (codified at 42 U.S.C. § 1396w).

<sup>56</sup>Florida began a pilot of its AVS in selected counties in October 2012, and implemented the program statewide in February 2013.

<sup>57</sup>The Supplemental Appropriations Act, 2008, required California, New Jersey, and New York to implement an AVS for aged, blind, and disabled applicants by the end of fiscal year 2009, and directed the Secretary of HHS to require the remaining states to implement their systems in a manner that results in a specified percentage of aged, blind, and disabled Medicaid applicants being subject to this type of asset verification each year of the 5-year period from fiscal year 2009 through fiscal year 2013.

<sup>58</sup>[GAO-12-749](#).

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## Agency Comments

We provided a draft of this report to HHS for review. HHS had no general comments but provided technical comments that we incorporated as appropriate.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Administrator of CMS and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix III.



Carolyn L. Yocom  
Director, Health Care

# Appendix I: Summary of Application Files Reviewed in Selected Counties in Three States

Of the 350 Medicaid applicants whose files we reviewed in selected counties in three states (Florida, New York, and South Carolina), most were over 75 years old, single, and female. (See table 6.) The median age of applicants was 84 years old. A majority of applicants—80 percent—had been living in a long-term care facility, such as a nursing home, at the time they applied for Medicaid coverage of nursing home care. The median length of time these applicants had been living in facilities was 2.3 months; the length of time ranged from less than 1 month to 6 years. Some applicants—15 percent—were already covered under Medicaid for basic medical services at the time that they applied for coverage of nursing home care. Additionally, 24 percent of the applicants had evidence in their application file that they received assistance from an attorney or financial planner in applying for Medicaid coverage for nursing home care.

**Table 6: Characteristics of Applicants Reviewed in Selected Counties in Three States (n=350)**

Characteristic	Number of applicants	Percent of applicants
<b>Age</b>		
65 to 69	29	8
70 to 74	38	11
75 to 79	48	14
80 to 84	68	19
85 to 89	87	25
90 and older	80	23
<b>Gender<sup>a</sup></b>		
Female	234	67
Male	114	33
<b>Marital status</b>		
Married	88	25
Single	262	75
<b>Living in long-term care facility at time of application</b>	<b>278</b>	<b>80</b>

Source: GAO analysis of Medicaid application data.

Note: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

<sup>a</sup>We did not have information on the gender of two applicants.

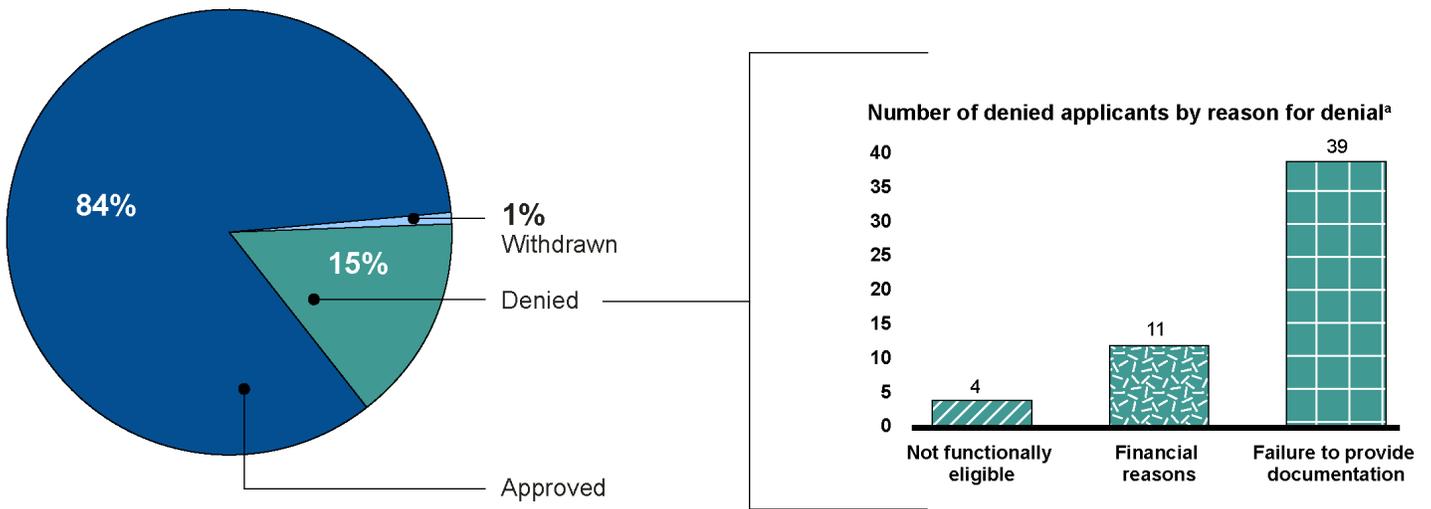
Over 80 percent of the applicants whose files we reviewed (294 of 350) were approved for Medicaid coverage for nursing home care, while 15 percent of applicants (52 of 350) were initially denied Medicaid coverage. (See fig. 5.) Most of these applicants (39 of 52) were denied because they failed to provide required documentation, a few were denied because they were not functionally eligible (4 of 52), and some applicants (11 of 52) were denied for financial reasons, including having income or resources that exceeded financial eligibility standards.<sup>1</sup> For applicants denied for having excess income, the median amount of excess income was \$77 per month; for those denied for excess resources, the median amount of excess resources was \$20,407.<sup>2</sup> Most applicants (9 of 11) who were initially denied for financial reasons reapplied and were later approved for Medicaid coverage for nursing home care. Of the 9 applicants who were later approved for Medicaid, 3 applicants spent down assets on long-term care or medical expenses, 2 applicants spent down assets on other goods or services, 2 applicants placed excess income into a qualified income trust, and 2 applicants were later approved for other or unknown reasons.

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<sup>1</sup>Three applicants were denied for more than one reason.

<sup>2</sup>The amount of excess income averaged \$166 per month and ranged from \$9 to \$412 per month. The amount of excess resources averaged \$59,063 and ranged from \$7,964 to \$182,649.

Figure 5: Application Status of Medicaid Applicants Reviewed in Selected Counties in Three States (n=350)



Source: GAO analysis of Medicaid application data.

Notes: Data for four counties were from applications submitted during state fiscal year 2012, while data for two counties were from applications submitted between July 1, 2012, and December 31, 2012.

<sup>a</sup>A total of 52 of the 350 applicants whose files we reviewed were denied. However, three applicants were denied for more than one reason and are included in the count for both categories for which they were denied.

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# Appendix II: Scope and Methodology

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To examine the financial characteristics of applicants approved for Medicaid nursing home coverage, we reviewed a random sample of Medicaid nursing home application files in selected counties in three states. To select states, we used information from a 2011 GAO web-based survey of Medicaid officials from each of the 50 states and the District of Columbia.<sup>1</sup> We scored states based on their survey responses to questions on the extent to which they:

1. verify applicants' assets with financial institutions;
2. conduct property record searches; and
3. obtain information covering the 60-month look-back period.

Weighing each question equally, we ranked states on the basis of their total score and placed them into three groups (low, medium, and high) using naturally occurring breaks in the data. (See table 7.) In selecting states, we considered the geographic dispersion of states, as well as the following:

- among states in the “low” group, we focused on states that reported generally obtaining only 1 month of documentation; and
- among states in the “high” group, we focused on states that reported conducting all three activities to some extent—verifying assets with financial institutions, conducting property searches, and obtaining 60 months of documentation.

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<sup>1</sup>GAO, *Medicaid Long-Term Care: Information Obtained by States about Applicants' Assets Varies and May be Insufficient*, [GAO-12-749](#) (Washington, D.C.: July 26, 2012). The survey requested information about the types of documentation, if any, that states require applicants for Medicaid coverage for long-term care to submit for 13 types of assets: (1) earned income, (2) unearned income, (3) financial and investment resources, (4) life insurance, (5) primary residence, (6) real property other than primary residence, (7) vehicles, (8) annuities, (9) burial contracts and prepaid funeral arrangements, (10) continuing care retirement community entrance fees, (11) life estates, (12) promissory notes or loans, and (13) trusts. In addition, the survey asked about the number of months of documentation states required for earned income, unearned income, and financial and investment resources. The survey also asked about states' practices to obtain information from third parties to verify applicants' assets, such as whether, and to what extent, states conduct data matches with 10 sources, including the Social Security Administration and the Internal Revenue Service, which primarily allow states to verify applicants' income. Finally, the survey asked about any additional documentation states require or additional steps states take to determine whether applicants transferred assets for less than fair market value during the 60-month look-back period.

**Table 7: Groups Used for State Sample Selection**

Group	Total Number of States	States
Low	14	Arizona, Arkansas, California, District of Columbia, Florida, Idaho, Massachusetts, Minnesota, Nebraska, New Mexico, North Dakota, Tennessee, Virginia, West Virginia
Medium	22	Alaska, Colorado, Delaware, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Michigan, Mississippi, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Utah, Washington, Wisconsin, Wyoming
High	15	Alabama, Connecticut, Hawaii, Maine, Maryland, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Rhode Island, South Carolina, Vermont

Source: GAO survey of Medicaid officials in 50 states and the District of Columbia, 2011.

From the ranked group of low and high states, we selected an initial set of states plus additional alternative states, and conducted interviews with state officials to determine whether they could provide us with needed data in order to select a sample of counties and application files to review.<sup>2</sup> If a state informed us they were unable to provide such data, we replaced the state with the next alternative state from the respective group. We interviewed officials from a total of 11 states. Officials from 6 states (2 high and 4 low) told us they were unable to produce needed data due to data system limitations. Officials from 1 state (a high state) told us they were technically able to produce needed data but would not be able to do so within a reasonable timeframe due to competing demands for their information technology resources. This left us with 4 states—2 high states and 2 low states—that were able to produce the data we needed. Based on these interviews, we selected one state from the low group (Florida) and two states from the high group (New York and South Carolina). In 2012, Medicaid spending for institutional long-term care was \$3.3 billion in Florida, \$11.5 billion in New York, and \$801 million in South Carolina.

To choose counties in our selected states, we considered three factors.

1. Size of the population aged 65 and older.<sup>3</sup>

<sup>2</sup>In making this selection, we excluded some states, such as states that had smaller populations, states that had lower median incomes among the population aged 65 and older; and states that, to our knowledge, had not implemented the Deficit Reduction Act of 2005 by our time period of interest, which was generally state fiscal year 2012.

<sup>3</sup>We used information from the *Profile of General Population and Housing Characteristics: 2010*, U.S. Census Bureau.

2. Median income of households with householders aged 65 and older.<sup>4</sup>
3. Number of Medicaid nursing home applications received.<sup>5</sup>

For the three factors, we ranked the counties within each selected state from high to low. We chose two counties that appeared in the top 20 ranking for all three factors in Florida,<sup>6</sup> or the top 10 ranking for all three factors in New York and South Carolina. (See table 8.)

**Table 8: Selected States and Counties**

Selected states	Selected counties
Florida	Palm Beach and Sarasota
South Carolina	Charleston and Richland
New York	Nassau and Westchester

Source: GAO.

Each selected state sent us a list of individuals aged 65 or over who submitted an application for Medicaid coverage for nursing home care during our requested time period in our selected counties—for Florida and South Carolina, we received a list of applicants who applied for services from July 1, 2011, through June 30, 2012, and for New York, we received a list of applicants who applied from July 1, 2012, through December 31, 2012. From the lists provided by the states, we randomly selected application files. In order to compensate for application files that would need to be skipped because we determined that they did not meet our criteria or lacked adequate information, we requested additional files in each county. When we determined that an application file was unusable, we included the next application file on our randomly generated list.

<sup>4</sup>We used information from the *Median Household Income in the Past 12 Months (in 2010 Inflation-Adjusted Dollars) by Age of Householder*, U.S. Census Bureau, 2006-2010 American Community Survey.

<sup>5</sup>We used information provided by state officials in each of the three states. For Florida and South Carolina, we used data on the number of applications received for Medicaid coverage for nursing home services from individuals aged 65 and older from July 1, 2011, through June 30, 2012. Due to limitations in New York's data systems, we used data on the number of applications received for Medicaid coverage for nursing home services from individuals aged 65 and older from July 1, 2012, through December 31, 2012.

<sup>6</sup>No counties in Florida were in the top 10 for all three factors.

We based the number of application files selected for review in each county on the total number of Medicaid nursing home applications that the county received from applicants aged 65 and older during our requested time period. We reviewed a total of 350 nursing home application files, of which 294 were approved for Medicaid coverage of nursing home care, including those that were approved and incurred a penalty period. (See table 9.)

**Table 9: Number of Files Reviewed, by Selected State and County**

Selected state	Selected county	Total number of files reviewed	Number of approved files reviewed
Florida	Palm Beach	67	53
	Sarasota	59	53
	<b>Total</b>	<b>126</b>	<b>106</b>
New York	Nassau	57	50
	Westchester	57	40
	<b>Total</b>	<b>114</b>	<b>90</b>
South Carolina	Charleston	52	47
	Richland	58	51
	<b>Total</b>	<b>110</b>	<b>98</b>
<b>Total</b>		<b>350</b>	<b>294</b>

Source: GAO.

We established a file review protocol whereby we reviewed and recorded the earliest Medicaid application for nursing home care in each file during the requested time period. If this application was denied, then we recorded data from that application, as well as certain data from the last application subsequently submitted by the time in which we reviewed files, if there was one. From each application, we collected and analyzed data on the amount and type of applicants' income and resources, including both countable and noncountable resources; certain applicant demographic information, such as marital status; and whether applicants were found to have transferred assets for less than fair market value (FMV) during the look-back period, how the assets were transferred, and the value of the assets transferred.

Since the selected counties used the information in these application files to determine eligibility for Medicaid coverage for nursing home care, we did not independently verify the accuracy of the information contained in the files. However, to ensure that the information we entered into our data collection instrument was consistent with the information found in the

application files, we conducted independent file verifications, which resulted in verification of at least 20 percent of the files reviewed. For some applicants, while the application file noted the applicant had income from a certain source or owned a certain type of resource, the amount of income or value of the resource was missing. This missing information may have affected the distributions of applicants by their amount of income or resources, as well as the medians, averages, and ranges of income and resources we report. Where applicable, we provide information on the extent of missing information in our analysis. Additionally, we conducted electronic tests of the data collected to determine whether there were obvious errors. In some cases, we combined variables to create new ones. For example, we collected and identified several types of applicant resources, but ultimately combined them into two categories—total resources and noncountable resources. Based on these procedures, we determined that the data were sufficiently reliable for the purposes of this report. The data from the 294 approved application files cannot be generalized to other approved applicants.

To identify the methods used to reduce countable assets to qualify for Medicaid coverage for nursing home care, we reviewed applicable federal laws and guidance, and spoke with officials from the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees the Medicaid program. We also used information from the following sources:

- Interviews with attorneys: We interviewed 9 of 16 attorneys recommended to us by the Director of the American Bar Association's Commission on Law and Aging. To select among the recommended attorneys, we considered the state in which the attorney practiced and our previously established grouping of the extent to which states take steps to verify applicants' assets. We selected attorneys from each group and from as many different states as possible, including states where we conducted file reviews.
- Undercover calls with law office representatives: We conducted undercover calls with representatives from a selection of law offices whose websites indicated that they offered Medicaid planning

services for elderly individuals.<sup>7</sup> We contacted 36 law offices for the undercover calls and determined 17 of the calls to be successful—that is, an attorney or another representative was willing to provide information over the phone and free of charge.<sup>8</sup> During the calls, our investigator used one of three scenarios in which he posed as an adult child seeking advice on ways in which he could obtain Medicaid coverage for nursing home care for his parent, while preserving the parent’s assets for a spouse or heirs. The different scenarios created were intended to test for potential differences in planning methods based on marital status and the timing of the need for nursing home care. Two scenarios involved an elderly parent with an immediate need for care (one for a married individual and one for a widow) and the third scenario involved an elderly parent for whom the need for long-term care services was not immediate, but would likely occur sometime in the future (possibly beyond the 60-month look-back period).

- Interviews with state Medicaid officials: We interviewed state Medicaid officials from the 3 states in which we reviewed files, as well as 9 additional states (for a total of 12 states) about the methods used by applicants in their state to reduce countable assets, and any steps that the state has taken to try to alleviate or eliminate the use of such methods. We selected the states based on information collected from our calls with attorneys, undercover calls with representatives from law offices, information from background literature, and data on the percentage of the population aged 65 and older and the percentage of elderly (age 65 and older) with income at or above 150 percent of the poverty level. We also considered geographic variation. The 12 states from which we interviewed Medicaid officials were: Colorado, Connecticut, Florida, Massachusetts, Michigan, New Jersey, New York, Ohio, Rhode Island, South Carolina, Vermont, and Washington.

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<sup>7</sup>To identify these professionals, we conducted an Internet search using search terms related to Medicaid planning and long-term care to identify attorneys or financial planners that offered Medicaid planning services for elderly individuals. We took the first 100 results from the search, all of which were law offices, and selected offices to contact based on the services they advertised providing, and taking into consideration geographic variation. In case some law offices were not responsive to our inquiry, we had a methodology for selecting alternatives to ensure continued geographic variation.

<sup>8</sup>We considered our contacts with the other 19 law offices as unsuccessful for the following reasons: the office informed us that they required a fee for consultation, an in-person consultation, or both (10 offices); the office informed us that they were unable to provide assistance, but could provide a referral to someone else (2 offices); or we were unable to make contact with the office after repeated contact attempts (7 offices).

- Interviews with county eligibility workers: We conducted in-person, semi-structured group interviews with eligibility workers from two counties from the three states in which we conducted file reviews, as well as from three additional states.<sup>9</sup> To select the three additional states, we used information from interviews with attorneys, undercover calls with representatives from law offices, and literature. We also took into consideration geographic distribution of states. To choose counties in the additional states, we ranked the counties in each state based on the size of the population aged 65 and older,<sup>10</sup> and median income of households with householders aged 65 and older.<sup>11</sup>

In addition, where feasible, we used information collected from our review of Medicaid nursing home application files to supplement the information obtained from our interviews and undercover calls.

To identify the information eligibility workers considered the most useful for identifying and verifying applicants' financial eligibility, we used information from the interviews conducted with county eligibility workers in two counties in six states.

We conducted this performance audit from September 2012 to May 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. We conducted our related investigative work in accordance with investigation standards prescribed by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>9</sup>We requested that the eligibility workers interviewed had reviewed Medicaid long-term care applications for at least 12 months, were considered specialists in Medicaid long-term care applications or primarily process these types of applications, and were not supervisors.

<sup>10</sup>We used information from the *Profile of General Population and Housing Characteristics: 2010*, U.S. Census Bureau.

<sup>11</sup>We used information from the *Median Household Income in the Past 12 Months (in 2010 Inflation-Adjusted Dollars) by Age of Householder*, U.S. Census Bureau, 2006-2010 American Community Survey.

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# Appendix III: Contact and Staff Acknowledgments

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## GAO Contact

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## Staff Acknowledgments

In addition to the contact named above, Michelle B. Rosenberg, Assistant Director; Kaycee M. Glavich; Robert Graves; Drew Long; Katherine Mack; Linda McIver; Vikki Porter; Daniel Ries; Laurie F. Thurber; and Jennifer Whitworth made key contributions to this report.

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