July 2012

MEDICAID LONG-TERM CARE

Information Obtained by States about Applicants' Assets Varies and May Be Insufficient

GAO Accountability * Integrity * Reliability

Highlights

Highlights of GAO-12-749, a report to congressional requesters

Why GAO Did This Study

Medicaid—a joint federal-state health care financing program for certain low-income individuals—paid for nearly half of the nation's $263 billion long-term care expenditures in 2010. To be financially eligible for Medicaid coverage for long-term care, applicants cannot have assets—income and resources—above certain limits. Federal law discourages individuals from artificially impoverishing themselves in order to establish financial eligibility for Medicaid. Specifically, those who transfer assets for less than fair market value during a specified time period—or "look-back" period—before applying for Medicaid may be ineligible for coverage for long-term care for a period of time. The DRA extended the look-back period to 60 months and introduced new requirements for the treatment of certain types of assets, such as annuities, in determining eligibility. States are responsible for assessing applicants' eligibility for Medicaid, the criteria for which varies by state.

GAO was asked to provide information on states' requirements and practices for assessing the financial eligibility of applicants for Medicaid long-term care coverage. GAO examined the extent to which states (1) require documentation of assets from applicants, (2) obtain information from third parties to verify applicants' assets, and (3) obtain information about applicants' assets that could be used to implement eligibility-related DRA provisions. From October 2011 to November 2011, GAO surveyed Medicaid officials from each of the 50 states and the District of Columbia. GAO also interviewed officials from CMS, the agency within HHS that oversees Medicaid.

View GAO-12-749. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

States reported requiring applicants to provide documentation for most of the 13 types of assets included in GAO's survey.

Number of States That Reported Requiring Documentation, by Type of Asset

Asset type	Description	Number of states
Income	Earned income	50
	Unearned income	49
Resources	Annuity, burial contract and prepaid funeral, financial and investment, life estate, and trust	51
	Life insurance, promissory note or loan, and real property other than primary residence	50
	Continuing care retirement community entrance fee	46
	Vehicle	38
	Primary residence	37

Source: GAO web-based survey administered to state Medicaid officials.

States varied in the extent to which they obtained information from third parties to verify applicants' assets. For example, all states conducted data matches with the Social Security Administration but used other sources to a lesser extent. While states' implementation of an electronic asset verification system (AVS) was required on a rolling basis beginning in 2009, no state had fully implemented an AVS at the time of GAO's survey. Among the implementation challenges reported by states were lack of resources and getting financial institutions to participate. Officials from the Centers for Medicare & Medicaid Services (CMS) were aware of states' progress and challenges and told GAO that they regularly communicated with states on AVS implementation.

On the basis of states' responses to questions about the extent of documentation required from applicants and information obtained from third parties, it is unclear whether some states obtain sufficient information to implement certain provisions of the Deficit Reduction Act of 2005 (DRA). For example, 31 states reported requiring less than 60 months of documentation from applicants and financial institutions. The results of GAO's survey raise questions about states' implementation of the DRA, but are not conclusive. CMS officials said that it is reasonable for states to only conduct reviews when there is reason to believe a transfer of assets occurred. GAO has additional work planned related to Medicaid long-term care financial eligibility.

States must balance the costs of eligibility determination efforts with the need to ensure that those efforts provide sufficient information to implement federal requirements. Given the complexities involved, it may be reasonable for states to adhere to a risk-based approach and focus their eligibility determination efforts on applicants who appear to be more likely to have assets or to have transferred assets that would make them ineligible. It is too early to assess the effectiveness of the AVS; its utility will ultimately depend on the breadth of the financial institutions participating and the depth of the information obtained.

The Department of Health and Human Services (HHS) concurred with GAO's findings and commented that GAO's comprehensive report will serve as a helpful resource for CMS and other interested parties.