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MEDICAID LONG-TERM CARE

Few Transferred Assets before Applying for Nursing Home Coverage; Impact of Deficit Reduction Act on Eligibility Is Uncertain





Highlights of [GAO-07-280](#), a report to congressional requesters

Why GAO Did This Study

The Medicaid program paid for nearly one-half of the nation's total long-term care expenditures in 2004. To be eligible for Medicaid long-term care, individuals may transfer assets (income and resources) to others to ensure that their assets fall below certain limits. Individuals who make transfers for less than fair market value (FMV) can be subject to a penalty that may delay Medicaid coverage. The Deficit Reduction Act of 2005 (DRA) changed the calculation and timing of the penalty period and set requirements for the treatment of certain types of assets. GAO was asked to provide data on the extent to which asset transfers for less than FMV occur.

GAO examined (1) the financial characteristics of elderly nursing home residents nationwide, (2) the demographic and financial characteristics of a sample of Medicaid nursing home applicants, (3) the extent to which these applicants transferred assets for less than FMV, and (4) the potential effects of the DRA provisions related to Medicaid eligibility for long-term care. GAO analyzed data from the Health and Retirement Study (HRS), a national panel survey, and from 540 randomly selected Medicaid nursing home application files from 3 counties in each of 3 states (Maryland, Pennsylvania, and South Carolina). State and county selections were based on the prevalence of several factors, including population, income, and demographics.

www.gao.gov/cgi-bin/getrpt?GAO-07-280.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Kathryn G. Allen at (202) 512-7118 or allenk@gao.gov.

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What GAO Found

Nationwide, HRS data showed that, at the time most elderly individuals entered a nursing home, they had nonhousing resources of \$70,000 or less—less than the average cost for a year of private-pay nursing home care. Overall, nursing home residents covered by Medicaid had fewer nonhousing resources and lower annual incomes, and were less likely to have reported transferring cash than non-Medicaid-covered nursing home residents.

Similar to the nationwide results, GAO's review of 540 Medicaid nursing home applications in three states showed that over 90 percent of the applicants had nonhousing resources of \$30,000 or less and 85 percent had annual incomes of \$20,000 or less. One-fourth of applicants owned homes, with a median home value of \$52,954. Over 80 percent of applicants had been living in long-term care facilities for an average of a little over 4 months at the time of their application. Of the 540 applicants, 408 were approved for Medicaid coverage for nursing home services the first time they applied and 122 were denied. Of the denied applicants, 56 were denied for having income or resources that exceeded the standards, 41 of whom submitted subsequent applications and were eventually approved, primarily by decreasing the value of their nonhousing resources. For about one-third of these applicants, at least part of the decrease in nonhousing resources could be attributed to spending on medical or nursing home care.

Approximately 10 percent of approved applicants in the three states (47 of 465) transferred assets for less than FMV, with a median amount of \$15,152. The average length of the penalty period assessed for the 47 applicants was about 6 months. However, only 2 of these applicants experienced a delay in Medicaid eligibility as a result of the transfers because many applicants' assessed penalties had expired by the time they applied for coverage.

The extent to which DRA long-term care provisions will affect applicants' eligibility for Medicaid is uncertain. DRA provisions regarding changes to penalty periods could increase the likelihood that applicants who transfer assets for less than FMV will experience a delay in Medicaid eligibility, but the extent of the delay is uncertain. Several factors could affect the extent to which DRA penalty period provisions actually delay eligibility for Medicaid. These factors include whether an applicant transferred assets for less than FMV before or after the DRA was enacted and a potential increase in requests for waived penalty periods due to undue hardship—circumstances under which individuals are deprived of medical care, food, clothing, shelter, or other necessities of life. Other DRA provisions may have limited effects on eligibility. For example, provisions pertaining to home equity may have limited impact because few applicants whose files GAO reviewed had home equity of sufficient value to be affected.

CMS, Maryland, and South Carolina generally agreed with the report's findings; Pennsylvania did not provide comments.

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Abbreviations

ADL	activities of daily living
CMS	Centers for Medicare & Medicaid Services
CPI	Consumer Price Index
DRA	Deficit Reduction Act of 2005
FMV	fair market value
HHS	Department of Health and Human Services
HRS	Health and Retirement Study
IADL	instrumental activities of daily living
SSI	Supplemental Security Income

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United States Government Accountability Office
Washington, DC 20548

March 26, 2007

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives

The Honorable Frank J. Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

The Honorable Sherrod Brown
United States Senate

Long-term care is costly—particularly nursing home care, which is estimated to average more than \$70,000 a year for a private-pay patient.¹ Medicaid, the joint federal-state health care financing program that covers certain categories of low-income individuals, paid for nearly one-half of the nation's total long-term care expenditures of about \$193 billion in 2004. As such, long-term care expenditures were a significant portion of total Medicaid expenditures in 2004, comprising 32 percent of the total \$296 billion spent. As the nation's population ages and more individuals are likely to need long-term care services, federal Medicaid spending is expected to nearly double in size during the next 10 years.² In light of the associated increased demand and burden that these trends place on

¹Congressional Budget Office, *The Cost and Financing of Long-Term Care Services*, April 19, 2005, Statement before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, and MetLife Mature Market Institute, *The MetLife Market Survey of Nursing Home & Home Care Costs* (Westport, Conn.: September 2006).

²Congressional Budget Office, *Medicaid Spending Growth and Options for Controlling Costs*, July 13, 2006, Statement before the Special Committee on Aging, U.S. Senate.

federal and state budgets,³ it is important to ensure that Medicaid coverage for long-term care is limited to those who are truly eligible.

Individuals applying for Medicaid coverage for long-term care must meet certain financial and functional eligibility criteria.⁴ To meet the financial eligibility criteria, individuals must have assets—both income and resources—that fall below established standards, which vary by state but are within standards set by the federal government.⁵ Not all assets are counted in determining financial eligibility for Medicaid. For example, states generally exclude—within specified limits—the value of an individual’s home, car, and prepaid burial arrangements. Additionally, federal law includes provisions to discourage individuals from artificially impoverishing themselves—for example, by transferring their assets to certain family members—in order to establish financial eligibility. Specifically, the law states that those who transfer assets for less than fair market value (FMV) during a specified “look-back” period—a period of time before application 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.

³GAO, *21st Century Challenges: Transforming Government to Meet Current and Emerging Challenges*, [GAO-05-830T](#) (Washington, D.C.: July 13, 2005); GAO, *Long-Term Care Financing: Growing Demand and Cost of Services Are Straining Federal and State Budgets*, [GAO-05-564T](#) (Washington, D.C.: Apr. 27, 2005); and *Long-Term Care: Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, [GAO-02-544T](#) (Washington, D.C.: Mar. 21, 2002).

⁴For this report, we focus on financial eligibility—specifically financial eligibility for Medicaid coverage for long-term care. However, individuals applying for Medicaid coverage for long-term care must also meet functional eligibility criteria that are established by each state and generally involve a degree of impairment measured by limitations in an individual’s ability to carry out activities of daily living (ADL)—eating, bathing, dressing, using the toilet, getting in and out of bed, and getting around the house—and instrumental activities of daily living (IADL), such as preparing meals, shopping for groceries, and getting around outside.

⁵Assets 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 savings accounts, stocks, 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.

Evidence on the extent to which individuals transfer assets for less than FMV to become financially eligible for Medicaid coverage for long-term care is generally limited and often based on anecdote. In September 2005, we reported that none of the nine states we contacted systematically tracked or analyzed data that would have provided information on the incidence of asset transfers made for less than FMV and the extent to which penalties were applied in their states.⁶ We also reported that other methods of reducing assets to qualify for Medicaid—such as using assets to reduce debt or make home modifications—did not always result in a penalty period. You asked us to expand on this work to provide more information on the extent to which asset transfers for less than FMV occur.

Subsequent to your request, in February 2006, the Deficit Reduction Act of 2005 (DRA), which amended certain existing provisions regarding asset transfers for less than FMV and introduced new requirements related to financial eligibility for Medicaid coverage for long-term care, was enacted.⁷ 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 federal requirements regarding certain types of assets, including an individual's home.

Given your request and the passage of the DRA, for this report we (1) examined the financial characteristics of elderly nursing home residents nationwide, including the extent to which they transferred cash; (2) for selected states, reviewed the demographic and financial characteristics of elderly individuals who applied for Medicaid coverage for nursing home care and if they applied more than once; (3) determined the extent to which elderly Medicaid nursing home applicants in selected states transferred assets for less than FMV and were subject to penalty periods; and (4) assessed the potential effects of the DRA provisions related to eligibility for Medicaid coverage for long-term care.

To examine the financial characteristics of elderly nursing home residents nationwide, including the extent to which they transferred cash, we analyzed data from the Health and Retirement Study (HRS), a longitudinal

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

⁷See Pub. L. No. 109-171, §§ 6011-6016, 120 Stat. 4, 61-67.

national panel survey, sponsored by the National Institute on Aging and conducted every 2 years by the University of Michigan. We used HRS data from 1992 through 2004 to estimate the (1) level of assets (nonhousing resources and income) held by elderly nursing home residents⁸ and (2) the percentage of residents who transferred cash or the deed to their home and the amount of the transfer.⁹ We further analyzed the above based on the reported source of payment to the nursing home—Medicaid or non-Medicaid (self-pay, Medicare, or other third-party insurance)—and assessed nonhousing resources relative to the average cost of a year of private-pay nursing home care. Because HRS only addressed cash and home deed transfers made to relatives, our analysis understates the percentage of residents who transfer and the amount of transfers by excluding transfers of other types of assets or transfers made to other individuals.¹⁰ Because HRS did not inquire about the reason for the transfers, no conclusions can be drawn regarding whether the survey respondents made these transfers for purposes of establishing eligibility for Medicaid coverage for nursing home care. To examine the characteristics of elderly individuals who applied for Medicaid coverage for nursing home care and the extent to which they transferred assets for less than FMV, we reviewed 540 randomly selected Medicaid nursing home application files from three selected counties in 3 selected states (180 files from each of the selected states).¹¹ To select states, we assessed the

⁸For the purpose of our analysis, we defined elderly nursing home residents as individuals aged 65 or older who have been surveyed prior to the survey period in which they entered into a nursing home and who said they (1) lived permanently in a nursing home, (2) spent at least 360 nights in a nursing home, or (3) spent 180 to 360 days in a nursing home and died in a later survey period; had at least 3 ADLs, cancer, or lung disease; or had heart disease and reported some difficulty with mobility. For those respondents who were couples, defined as both married couples and a small percentage of nonmarried individuals living together, we required that at least one person in the household meet the above criteria.

⁹Since the data for this analysis are from multiple years, we converted all dollar figures into 2004 dollars, using the current methods series of the Consumer Price Index (CPI) for all urban consumers.

¹⁰HRS asked respondents whether they had transferred cash to a child/grandchild during the survey period prior to the interview. Additionally, HRS asked respondents whether they had transferred the deed to their home to a child/grandchild. The data we report here, therefore, refer only to these transfers.

¹¹The dates of the applications we analyzed ranged from March 1989 to April 2006. Ninety-eight percent of the applications we analyzed were from 2005 or before. As a result, information regarding Medicaid eligibility levels is provided for 2005, with notes added to explain the 2007 levels when they differ.

prevalence of five factors in each of the 50 states and the District of Columbia;¹² on the basis of this assessment, we ranked the states into three clusters (low, medium, and high) based on the prevalence of the five factors and judgmentally selected one state from each cluster.¹³ The 3 selected states were South Carolina (low), Maryland (medium), and Pennsylvania (high). We then judgmentally selected three counties in each state based on the prevalence of four factors.¹⁴ From the 540 Medicaid nursing home application files, we collected and analyzed data on the applicants' demographic characteristics, income, nonhousing resources, and home value. We also collected and analyzed data on the number of applicants who transferred assets for less than FMV and the amount they transferred. Because of the parameters set in our methodology, the data from the 540 Medicaid nursing home application files can be generalized to the county level but cannot be generalized to the state or national level.¹⁵ To assess the potential effects of the DRA, we relied on data from HRS and the 540 Medicaid nursing home application files, as well as interviewing officials from the 3 selected states regarding Medicaid eligibility determination practices, including the process for identifying whether applicants had transferred assets.¹⁶ We reviewed applicable federal law related to Medicaid and asset transfers, as well as related guidance from the Centers for Medicare & Medicaid Services (CMS). We also spoke with researchers and CMS officials. We considered the HRS data as well as data from the Medicaid application files to be sufficiently reliable for our purposes. (See app. I for more information about our scope and

¹²Throughout this report, the term state refers to the 50 states and the District of Columbia.

¹³The five factors were (1) percentage of the population aged 65 and over, (2) cost of a nursing home stay for a private room for a private-pay patient, (3) proportion of elderly (aged 65 and over) with incomes at or above 250 percent of the U.S. poverty level (\$23,925 for a single-person household in 2005), (4) reported Medicaid nursing home expenditures, and (5) availability of legal services specifically to meet the needs of the elderly and disabled.

¹⁴The four factors were (1) number of Medicaid applicants or enrollments for nursing home coverage from individuals aged 65 and over, (2) number of licensed nursing home beds, (3) population aged 65 and over, and (4) median household income.

¹⁵We included the following counties in our sample: South Carolina—Orangeburg (Low), Charleston (Medium), and Greenville (High); Maryland—Baltimore City (Low), Baltimore (Medium), and Montgomery (High); and Pennsylvania—Philadelphia (Low), Allegheny (Medium), and Montgomery (High).

¹⁶The effects of the DRA provisions are not incorporated into our other analyses because (1) the HRS data we used are from years prior to the DRA's enactment, and (2) the data from the application file reviews are from prior to the three states' implementation of the DRA.

methodology.) We performed our work from October 2005 through January 2007 in accordance with generally accepted government auditing standards.

Results in Brief

Nationwide, at the time most elderly individuals entered a nursing home, they had nonhousing resources of \$70,000 or less—which is less than the average cost for a year of private-pay nursing home care. According to data from HRS, median nonhousing resources for Medicaid-covered elderly nursing home residents (\$48) were lower than for the non-Medicaid-covered elderly nursing home residents (\$36,123). Regarding income, approximately 90 percent of elderly nursing home residents had annual incomes of \$20,000 or less. Median annual income for Medicaid-covered elderly nursing home residents (\$9,719) was about half that for non-Medicaid-covered residents (\$18,600). Similarly, the percentage of Medicaid-covered elderly nursing home residents who reported transferring cash (9.2 percent) was less than half that for non-Medicaid-covered residents (23.2 percent) at time of entry into the nursing home. However, the median amount of cash transferred as reported by Medicaid-covered residents and non-Medicaid-covered residents did not vary greatly.

Similar to the nationwide results, our review of 540 Medicaid nursing home application files in selected counties in three states showed that about 90 percent of the applicants had total nonhousing resources of \$30,000 or less and 85 percent had annual incomes of \$20,000 or less. Over 80 percent of applicants had been living in long-term care facilities for an average of a little over 4 months at the time of their Medicaid application. The majority of the applicants were single females, and 25 percent of the applicants (137 applicants) owned homes. For the 112 applicants for whom we were able to determine a value for their homes, the median value was \$52,954. Overall, 408 applicants (76 percent) were approved for Medicaid coverage for nursing home services the first time they applied, and 465 applicants (86 percent) were eventually approved. Of the 122 applicants who were denied eligibility, 56 were denied due to having income or resources that exceeded the standards, 41 of whom submitted subsequent applications and were eventually approved, primarily by decreasing the value of their nonhousing resources. Specifically, their median nonhousing resources decreased from \$22,380 to \$10,463, with a maximum decrease of \$283,075. For about one-third of these applicants, at least part of the decrease in nonhousing resources could be attributed to spending on medical or nursing home care.

Approximately 10 percent of the approved applicants (47 of 465) whose files we reviewed had transferred assets for less than FMV during the 36-month look-back period; however, these applicants rarely experienced a delay in Medicaid eligibility as a result of the transfers because many applicants' assessed penalties had expired by the time they applied for coverage. The proportion of approved applicants found to have transferred assets for less than FMV varied, ranging from a high of approximately 24 percent of approved applicants in a South Carolina county to a low of approximately 4 percent in a Pennsylvania county. Among the 47 approved applicants who transferred assets for less than FMV, the average length of the penalty period assessed was about 6 months. However, only 2 of the applicants experienced a delay in their eligibility for Medicaid coverage for nursing home services as a result of transferring assets. The other applicants were either not assessed a penalty, because the penalty would have been for less than 1 month of coverage (9 applicants), or the penalty they were assessed had expired by the time they submitted their Medicaid application (36 applicants). The median amount of all assets transferred for less than FMV was \$15,152, and ranged from \$1,000 to \$201,516. Most of the asset transfers involved the transferring of financial holdings, such as gifts of cash or stocks, and applicants' children or grandchildren were the most common recipients of the transfers.

The extent to which new long-term care provisions in the DRA may affect applicants' eligibility for Medicaid coverage for long-term care is uncertain. Primarily because the DRA changed the beginning date of the penalty period, there is an increased likelihood that applicants who transfer assets for less than FMV will experience delays in Medicaid eligibility. For example, if the DRA penalty period provisions had been in effect for the sample of applications we reviewed, all 47 of the approved applicants who transferred assets for less than FMV would have experienced a delay in eligibility for Medicaid coverage for nursing home care, with a median delay of about 3 months. Since the new provisions were not yet in effect, however, only 2 applicants actually experienced delays obtaining Medicaid coverage because many applicants' penalty periods had expired by the time they applied for coverage. While the new provisions in the DRA have the potential to delay eligibility for those who transfer assets for less than FMV during the look-back period, changes in individuals' financial decision making—specifically decisions regarding whether to transfer assets below FMV—could affect the extent to which such delays actually occur. Additionally, individuals can request that the state waive their penalty periods because the application of the penalty would result in an undue hardship—that is, it would deprive the individual

of critically needed medical care, food, clothing, shelter, or other necessities of life. Given the increases in the incidence or length of penalty periods as a result of the DRA, more applicants may request that the state waive their penalty periods. The effects of other DRA provisions on individuals' eligibility for Medicaid may be limited. For example, few applicants whose files we reviewed appeared to have home equity of sufficient value to be affected by the DRA provisions.

We received comments on a draft of this report from CMS and state officials from Maryland and South Carolina. In commenting, CMS, Maryland, and South Carolina generally agreed with our findings. Technical comments from CMS were incorporated as appropriate.

Background

To qualify for Medicaid coverage for long-term care, individuals must be within certain eligibility categories, such as children or those who are aged or disabled, and meet functional and financial eligibility criteria. Within broad federal standards, states determine if an individual meets the functional criteria by assessing limitations in an individual's ability to carry out activities of daily living (ADL) and instrumental activities of daily living (IADL). The financial eligibility criteria are based on individuals' assets—income and resources together. The Medicaid statute requires states to use specific income and resource standards in determining eligibility; these standards differ based on whether an individual is married or single. If a state determines that an individual has transferred assets for less than FMV, the individual may be ineligible for Medicaid coverage for long-term care for a period of time.

Financial Eligibility for Medicaid Coverage for Long-Term Care

Most individuals requiring Medicaid coverage for long-term care services become financially eligible for Medicaid in one of three ways:

1. Individuals who participate in the Supplemental Security Income (SSI) program, which provides cash assistance to aged, blind, or disabled

individuals with limited income and resources, generally are eligible for Medicaid.¹⁷

2. Individuals who incur high medical costs may “spend down” into Medicaid eligibility because these expenses are deducted from their income. Spending down may bring their income below the state-determined income eligibility limit. Such individuals are referred to as medically needy. As of 2000, 36 states had a medically needy option, although not all of these states extended this option to the aged and disabled or to those needing nursing home care.
3. 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 (\$1,737 per month in 2005) are eligible for Medicaid.¹⁸ Individuals eligible under this option must apply all of their income, except for a small personal needs allowance, toward the cost of nursing home care.¹⁹ The National Association of State Medicaid Directors reported that, as of 2003, at least 38 states had elected this option.²⁰

Medicaid policy bases its characterization of assets—income and resources—on SSI policy. Income is something, paid either in cash or in kind, received during a calendar month that is used or could be used to meet food or shelter needs; resources are cash or things that are owned that can be converted to cash. (Table 1 provides examples of different types of assets.) In establishing policy for determining financial eligibility for Medicaid coverage for long-term care, states can decide, within federal

¹⁷Not all SSI recipients automatically qualify for Medicaid. Under Section 1902(f) of the Social Security Act, states may use more restrictive Medicaid eligibility standards than they had in place in 1972 rather than rules that would otherwise apply under the SSI program. As of June 2003, 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.

¹⁸For 2007, 300 percent of the SSI benefit was \$1,869 per month.

¹⁹A personal needs allowance is an amount, subject to a federal minimum (\$30 a month), excluded from an institutionalized individual’s income to pay for the individual’s clothing and other personal needs.

²⁰See National Association of State Medicaid Directors, *Aged, Blind and Disabled Eligibility Survey* (Washington, D.C.: American Public Human Services Association, 2002), <http://www.nasmd.org/eligibility/default.asp> (downloaded July 31, 2005).

standards, which assets are countable or not. For example, states may disregard certain types or amounts of income and may elect not to count certain resources.²¹

Table 1: Types of Assets and Examples

Type of asset	Examples
Income	<ul style="list-style-type: none"> • Money earned from work • Money generated from resources, such as interest, dividends, and annuity payments^a • Money received from other sources, such as Social Security, worker's compensation, and unemployment benefits
Resources	<ul style="list-style-type: none"> • Cash • Bank accounts • Stocks • Bonds • Trusts^b • Annuities • Real estate • Vehicles (such as automobiles and boats) • Life insurance

Source: GAO analysis of SSI requirements.

^aSome resources produce income. For example, an annuity is a financial instrument that provides income over a defined period of time for an initial payment of principal. The principal of an annuity may be considered a resource, while the payments it generates are considered income.

^bA trust is any 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.

In most states, to be financially eligible for Medicaid coverage for long-term care services, an individual must have \$2,000 or less in countable resources (\$3,000 for a couple). However, specific income and resource standards vary depending on the way an individual becomes eligible for Medicaid (see table 2).

²¹Although noncountable resources vary by state, for purposes of determining Medicaid eligibility for long-term care, they generally include an individual's home (typically if the individual expresses the intent to return home), an automobile, household goods and personal effects, burial spaces, and life insurance and burial arrangements up to a certain value, among other things.

Table 2: Income and Resource Standards for Selected Ways of Becoming Eligible for Medicaid, as of 2005

Ways of becoming eligible for Medicaid	Income standard	Resource standard
Mandatory coverage		
SSI ^a	Less than \$579 per month for an individual and less than \$869 per month for a couple ^b	Countable resources of less than \$2,000 for an individual, and less than \$3,000 for a couple
State-elected coverage (optional)		
Medically needy	State-set income standard; individuals may “spend down” to eligibility by deducting incurred medical expenses from income	State-set resource standard 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 (\$1,737 per month) for an individual ^c	Same as SSI

Sources: GAO analysis of Medicaid eligibility requirements and Schneider, et al., *The Medicaid Resource Book* (Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured, July 2002), 30.

^aNot all SSI recipients automatically qualify for Medicaid. Under Section 1902(f) of the Social Security Act, states may use more restrictive Medicaid eligibility standards than they had in place in 1972 rather than federal SSI rules. As of June 2003, 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.

^bIn 2007, the standard was less than \$623 per month for an individual and less than \$934 per month for a couple.

^cIn 2007, the standard was no higher than \$1869 per month.

Spousal Impoverishment Protections

The Medicaid statute requires states to use specific minimum and maximum resource and income standards in determining eligibility when one spouse is in an institution, such as a nursing home, and the other remains in the community (referred to as the community spouse). This enables the institutionalized spouse to become eligible for Medicaid while leaving the community spouse with sufficient assets to avoid impoverishment.

- **Resources.** The community spouse may retain an amount equal to one-half of the couple’s combined countable resources, up to a state-specified

maximum resource level.²² If one-half of the 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.²³ The amount that the community spouse is allowed to retain is generally referred to as the community spouse resource allowance.²⁴

- **Income.** The community spouse is allowed to retain all of his or her own income. States establish a minimum amount of income—a minimum needs allowance²⁵—that a community spouse is entitled to retain.²⁶ Prior to the DRA, if the community spouse's income was less than the minimum needs allowance, then states could allow the difference to be made up in one of two ways: by requiring the transfer of income from the institutionalized spouse (called the income-first approach) or by allowing the community spouse to keep resources above the community spouse resource allowance, so that the additional resources could be used to generate more income (the resource-first approach).²⁷ Under the DRA, states must apply the income-first method.²⁸

²²States' maximum resource levels cannot exceed the maximum federal standard. As of January 1, 2005, the federal maximum was \$95,100; for 2007, it was \$101,640.

²³States' minimum resource levels cannot be less than the federal minimum standard. As of January 1, 2005, the federal minimum was \$19,020; it was \$20,328 in 2007.

²⁴Technically, the community spouse resource allowance is the amount of additional resources that the community spouse keeps above the spousal share of resources. Generally, however, the community spouse resource allowance is used to refer to the total resources that the community spouse is permitted to retain. See 42 U.S.C. § 1396r-5(f)(2); see also *Wisconsin Department of Health and Family Services v. Blumer*, 534 U.S. 473, 482-83 (2001). According to CMS, the community spouse resource allowance means "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." 66 *Fed. Reg.* 46763, 46768 (2001).

²⁵The Social Security Act terms this the minimum monthly maintenance needs allowance. Throughout this report, we refer to this as the minimum needs allowance.

²⁶As of July 1, 2005, federal standards specified that the minimum needs allowance can be no lower than \$1,603.75 and no higher than \$2,377.50 per month; in 2007, the minimum needs allowance could range from \$1,650 to \$2,541 per month.

²⁷If the shortfall in income could not be made up completely using one of the approaches, then a combination of both approaches could be used.

²⁸Prior to the DRA, approximately half of states required the use of the income-first method.

Transfers of Assets

Federal law limits Medicaid payments for long-term care services for persons who transfer assets for less than FMV within a specified time period. 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 individual (or his or her spouse, if married) transferred assets to another person or party and, if so, whether the transfer was for less than FMV.²⁹ If a transfer of assets for less than FMV is detected, the individual is ineligible for Medicaid coverage for long-term care for a period of time, called the penalty period. The penalty period is calculated by dividing the dollar amount of the assets transferred by the average monthly private-pay rate for nursing home care in the state (or the community, at the option of the state). For example, if an individual transferred \$10,000 in assets, and private facility costs averaged \$5,000 per month in the state, the penalty period would be 2 months.

Federal law exempts certain transfers for less than FMV from the penalty provisions even if they are made within the look-back period. Exemptions include transfers of assets to the individual’s spouse, another individual for the spouse’s sole benefit, or a child who is considered to be disabled under federal law. Additional exemptions from the penalty provisions include the transfer of a home to an individual’s spouse, or minor or disabled child who meets certain criteria; an adult child residing in the home who has been caring for the individual for a specified time period; or a sibling residing in the home who meets certain conditions.³⁰ Transfers do not result in a penalty if the individual can demonstrate to the state that the transfer was made exclusively for purposes other than qualifying for Medicaid.³¹ 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

²⁹Federal 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 a similar institution or certain recipients of home and community-based services. See Social Security Act § 1917(e)(3). States have the option to apply such provisions to noninstitutionalized individuals.

³⁰For the transfer of a home to a sibling to be exempt from transfer penalty provisions, the sibling must have an equity interest in the home and must have resided in the individual’s home for at least 1 year immediately prior to the date the individual became institutionalized.

³¹According to CMS’s *State Medicaid Manual*, an individual must provide “convincing evidence” as to the specific purpose for which the asset was transferred. Verbal assurances are not sufficient.

that the individual's health or life would be endangered or (2) food, clothing, shelter, or other necessities of life.

Prior to the DRA, the look-back period for asset transfers was generally 36 months.³² If the state identified transfers for less than FMV during this period, then the state was required to impose a penalty period that began at approximately the date of the asset transfer.³³ As a result, some individuals' penalty periods had already expired by the time they applied for Medicaid coverage for long-term care and therefore they were eligible when they applied.

The DRA

The DRA modified some of the eligibility requirements for Medicaid coverage for long-term care, including provisions related to asset transfers, and introduced new requirements. Most, but not all, of these DRA provisions became applicable on the date the law was enacted, February 8, 2006. In general, these DRA provisions do not apply to transfers that occurred prior to the law's enactment.

The DRA extended the look-back period, changed the beginning date of the penalty period, and provided additional conditions on the application process for undue hardship waivers. (See table 3.)

³²For individuals in institutions, the look-back period was 36 months (or 60 months for certain types of trusts) from the date the individual was institutionalized and applied for Medicaid.

³³States had the option to begin the penalty period on either the first day of the month in which the asset was transferred for less than FMV or the first day of the month following the month of transfer.

Table 3: DRA Changes to Provisions Related to Transfers of Assets

Topic	Provisions prior to the DRA	DRA provisions
Look-back period	36 months for most assets, 60 months for transfers involving certain types of trusts, from the date the individual was institutionalized and applied for Medicaid	60 months for all assets, from the date the individual was institutionalized and applied for Medicaid ^a
Beginning date of penalty period	Approximately the date of the asset transfer ^b	Generally, 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 is eligible for Medicaid and would otherwise be receiving coverage for long-term care services, were it not for ineligibility due to the imposition of the penalty period
Undue hardship	Penalty period for asset transfers would not be applied if the state determines that the denial of eligibility would create an undue hardship as determined on the basis of criteria established by the Secretary of Health and Human Services (HHS)	<ul style="list-style-type: none"> • Undue hardship exists if application of the penalty period would deprive an individual of (1) medical care such that the individual's health or life would be endangered or (2) food, clothing, shelter, or other necessities of life^c • Allows the long-term care facility to apply for an undue hardship provision on behalf of a resident, with that resident's consent

Source: GAO analysis of the Social Security Act before and after the DRA.

^aThe DRA provides that only transfers of assets made on or after February 8, 2006, are subject to the 60-month look-back period. Thus, transfers made prior to February 8, 2006, could result in a penalty period only if they occur within 36 months from the date an institutionalized person submitted an application. In contrast, transfers made on or after February 8, 2006, could result in a penalty period if they occur within 60 months of the date of application. Given this, as a practical matter, the look-back period will gradually increase from 36 to 60 months and will reach the full 60 months on February 8, 2011.

^bStates had the option to begin the penalty period on either the first day of the month in which the asset was transferred for less than FMV or the first day of the month following the month of transfer.

^cThe criteria for determining undue hardship are the same as those that had previously been established by the Secretary of HHS in Medicaid guidance, namely *The State Medicaid Manual*.

The DRA also introduced several new provisions, which are summarized in table 4.

Table 4: New Provisions Introduced by the DRA Related to Medicaid Eligibility for Long-Term Care and Asset Transfers

DRA provision	Description
Asset review and verification	
Annuities	<ul style="list-style-type: none"> • States are required to treat the purchase of an annuity as a transfer for less than 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. • 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. • Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care services that are considered as individual retirement accounts or purchased with the proceeds of certain retirement accounts and meet certain federal tax code requirements are not considered transfers for less than FMV.
Continuing care retirement communities	States are required to consider certain entrance fees for continuing care retirement communities or life care communities as countable resources.
Home equity	An individual with an equity interest in his/her home of more than \$500,000 is excluded from eligibility for Medicaid payment for long-term care. (A state can elect to increase this value up to \$750,000.) However, an individual would not be excluded from eligibility if his/her spouse, child under age 21, or child who is considered blind or disabled lives in the home.
Income-first rule	When calculating the community spouse’s minimum needs allowance, states are required to allocate the available income of the institutionalized spouse before allocating any available resources to the community spouse.
Life estates	A purchase of a life estate interest in another person’s home is treated 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. ^a
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.
Imposition of penalty period	
Imposition of partial months of ineligibility	A state cannot “round down” or disregard any fractional period of ineligibility when determining the penalty period.
Treatment of multiple transfers	For an individual or an individual’s spouse who makes multiple fractional transfers of assets (i.e., transfers for less than FMV that are worth less than 1 month of nursing home cost of care) during the look-back period, states may determine the penalty period by treating the total, cumulative uncompensated value of all the assets transferred as one transfer.

Source: GAO analysis of the DRA.

^aA life interest, or life estate, is an interest in real property that gives the owner of the interest the right to use and possess the property only for the duration of the life of a person, usually the person who occupies the premises.

Nationwide, Most Nursing Home Residents' Nonhousing Resources Were Lower than Annual Nursing Home Costs

Nationwide, most elderly individuals had nonhousing resources valued under \$70,000 at the time they entered the nursing home; nursing home care is estimated to cost over \$70,000 a year for a private-pay patient.³⁴ In general, Medicaid-covered elderly nursing home residents had lower nonhousing resources and income at the time of entry than non-Medicaid-covered residents. The percentage of Medicaid-covered elderly nursing home residents who reported transferring cash was lower and the median amounts they reported transferring were similar to those for non-Medicaid-covered residents.

Medicaid-Covered Nursing Home Residents Generally Had Fewer Assets than Those Not Covered by Medicaid

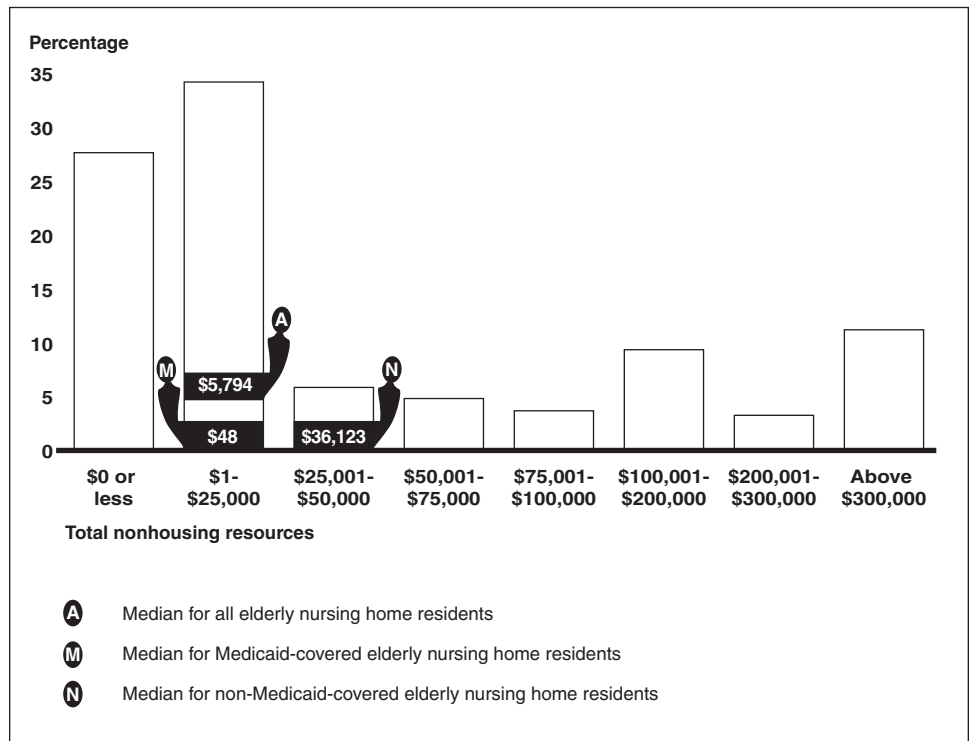
According to data from the HRS, nursing home residents covered by Medicaid had fewer assets than residents not covered by Medicaid. Over 70 percent of all elderly nursing home residents had nonhousing resources of \$70,000 or less at the time they entered the nursing home, which is less than the estimated average annual cost for nursing home care.³⁵ Median nonhousing resources for all elderly nursing home residents were \$5,794 at the time they entered the nursing home.³⁶ (See fig. 1.) Sixty-two percent of all elderly nursing home residents had nonhousing resources of \$25,000 or less while 11 percent had nonhousing resources of \$300,000 or above. Median nonhousing resources for Medicaid-covered elderly nursing home residents (\$48) were lower than for non-Medicaid-covered residents (\$36,123). Approximately 92 percent of Medicaid-covered residents had nonhousing resources of \$25,000 or less compared to 46 percent of non-Medicaid-covered residents.

³⁴For the purpose of our analysis, "nonhousing resources" refers to the net value of stocks, checking accounts, CDs, bonds, individual retirement accounts/Keogh plans, other real estate, vehicles, business, and other resources, excluding the home as well as mortgages and loans on the home. Since the data for this analysis are from multiple years, we converted all dollar figures into 2004 dollars, using the current methods series of the CPI for all urban consumers.

³⁵For couples, nonhousing resources are assessed at the household level.

³⁶Mean (average) nonhousing resources were \$121,201 and ranged from less than zero to \$6,625,498. Ninety-five percent of all elderly nursing home residents had nonhousing resources of \$622,506 or below. An individual or household can have resources valued at less than zero if debt is greater than the value of resources.

Figure 1: Distribution of Nonhousing Resources as Reported by Elderly Nursing Home Residents at the Time They Entered the Nursing Home, 1992-2004



Source: GAO analysis of data from the Health and Retirement Study, 1992-2004.

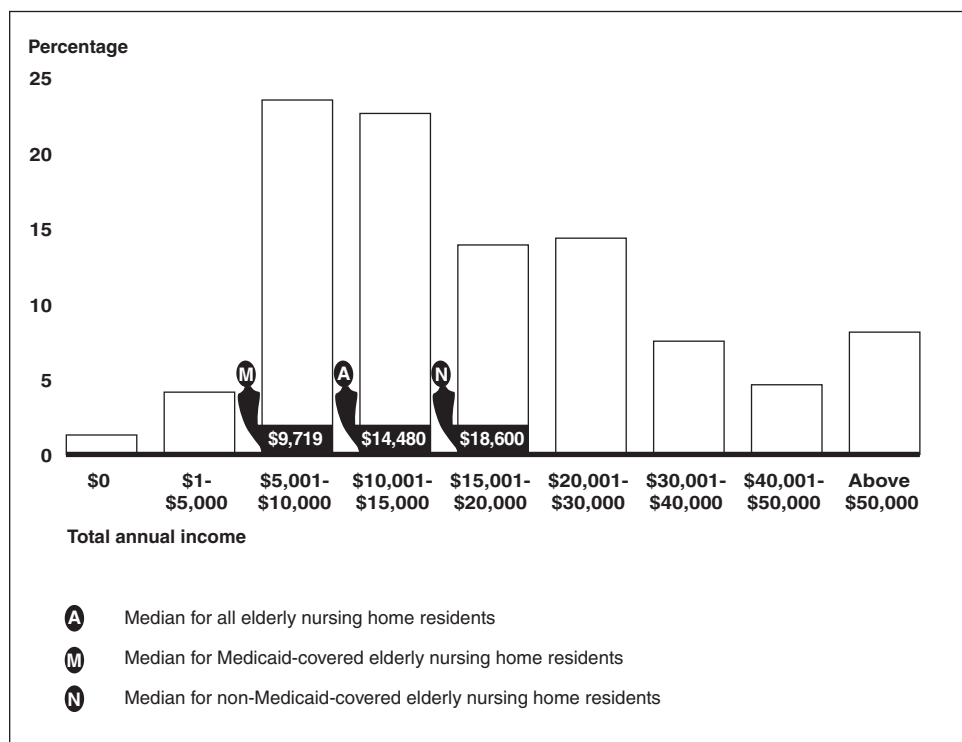
Note: The data for this analysis are from multiple years; therefore, we converted all dollar figures into 2004 dollars, using the current methods series of the Consumer Price Index (CPI) for all urban consumers.

Approximately 92 percent of all elderly nursing home residents had an annual income of \$50,000 or less at the time they entered the nursing home; about 65 percent of elderly nursing home residents had incomes of \$20,000 or less. Median annual income for elderly nursing home residents was \$14,480 at the time of entry.³⁷ (See fig. 2.) Median annual income of Medicaid-covered elderly nursing home residents (\$9,719) was about half that of non-Medicaid-covered residents (\$18,600). Approximately 90 percent of Medicaid-covered elderly nursing home residents had annual

³⁷Mean (average) annual income for all elderly nursing home residents was \$22,182 and it ranged from zero to \$556,357 at the time they entered the nursing home. Ninety-five percent of all elderly nursing home residents had annual income of \$58,773 or below.

incomes of \$20,000 or less compared to approximately 53 percent of non-Medicaid-covered residents.

Figure 2: Distribution of Annual Income as Reported by Elderly Nursing Home Residents at the Time They Entered the Nursing Home, 1992-2004



Source: GAO analysis of data from the Health and Retirement Study, 1992-2004.

Note: The data from this analysis are from multiple years; therefore, we converted all dollar figures into 2004 dollars, using the current methods series of the CPI for all urban consumers.

Nationwide, Fewer Medicaid-Covered Nursing Home Residents Reported Transferring Cash Compared with Non-Medicaid-Covered Residents

Nationwide, the percentage of Medicaid-covered elderly nursing home residents who reported transferring cash was about half that of non-Medicaid-covered residents at the time they entered the nursing home and during the 4 years prior to entry. For example, at the time they entered the nursing home, 9.2 percent of Medicaid-covered residents reported transferring cash, compared with 23.2 percent of non-Medicaid-covered residents. However, the median amount of cash transferred as reported by Medicaid-covered residents and non-Medicaid-covered residents did not vary greatly.³⁸ (See table 5.)

Table 5: Amounts of Cash Transferred at Entry and Prior to Entry into the Nursing Home Reported by Elderly Nursing Home Residents, by Payer Source, 1992-2004

Time in relation to entry into the nursing home	Payer source	Percentage of residents who transferred cash	Amount of cash transferred (in 2004 dollars)				
			Minimum	Median (midpoint)	Mean (average)	95th percentile	Maximum
At entry	Medicaid	9.2	\$1	\$2,194	\$5,439	\$23,174	\$23,174
	Non-Medicaid	23.2	12	2,194	9,328	30,986	383,928
2 years prior to entry	Medicaid	12.4	6	2,194	4,655	14,873	43,380
	Non-Medicaid	23.8	116	2,194	5,935	23,174	74,366
4 years prior to entry	Medicaid	12.0	46	1,239	2,278	9,915	15,493
	Non-Medicaid	25.1	110	1,859	6,119	19,614	301,266

Source: GAO analysis of data from the Health and Retirement Study, 1992-2004.

Note: The data from this analysis are from multiple years; therefore, we converted all dollar figures into 2004 dollars, using the current methods series of the CPI for all urban consumers.

³⁸Very few elderly nursing home residents (approximately 5 percent or less) reported transferring the deeds to their homes to their children or grandchildren.

Majority of Medicaid Applicants in Selected Counties in Three States Had Few Nonhousing Resources and Were Approved upon Initial Application

Similar to the nationwide results, the majority of the 540 applicants whose Medicaid nursing home application files we reviewed in selected counties in three states (Maryland, Pennsylvania, and South Carolina) had few nonhousing resources.³⁹ The majority of applicants (approximately 65 percent) were single females. About 76 percent of all applicants were approved the first time they applied, while the remaining applicants (23 percent) were initially denied, often for financial reasons—having income or resources that exceeded the states’ financial eligibility standards. About three-quarters of the applicants initially denied only for financial reasons were subsequently approved, primarily after the value of their nonhousing resources decreased. For the applicants who were initially denied for financial reasons, the time span between their initial and subsequent applications averaged a little over 5 months. During this time, their median nonhousing resources decreased from \$22,380 to \$10,463, with a maximum decrease of \$283,075. For about one-third of these applicants who were initially denied for financial reasons and were subsequently approved, at least part of the decrease in their nonhousing resources could be attributed to spending on medical or nursing home care.

Majority of Medicaid Applicants Reviewed Were Single, Female, and Had Nonhousing Resources of Less than \$30,000

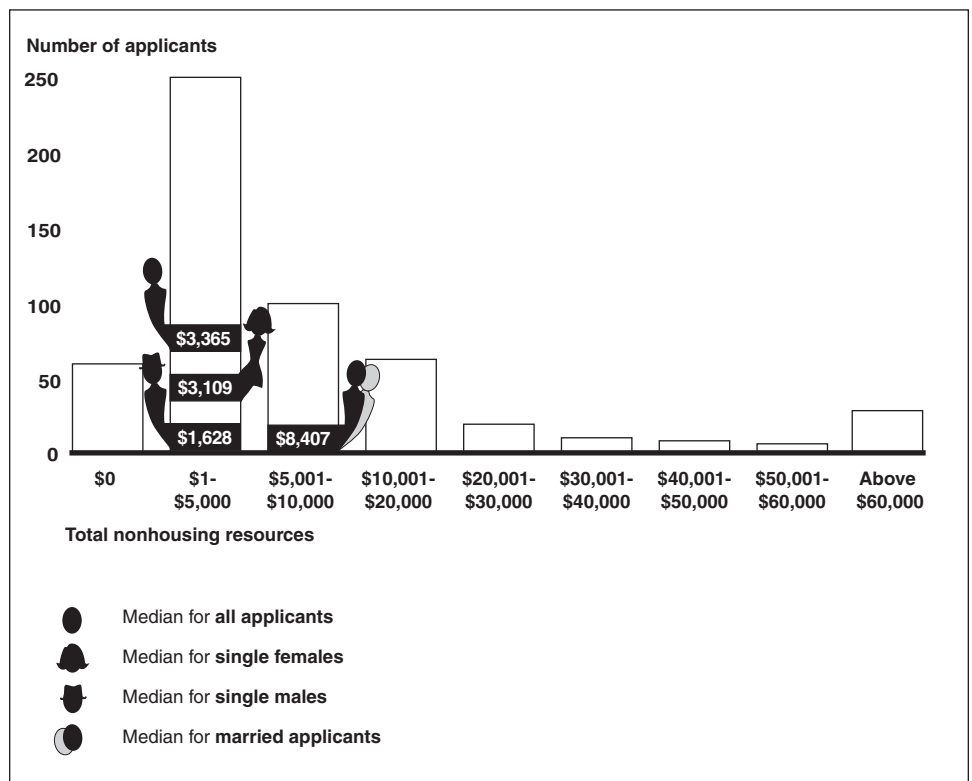
Of the 540 Medicaid nursing home application files we reviewed in selected counties in three states, about 75 percent of the applicants were female, most of whom were single. Over 80 percent of the applicants were already living in a long-term care facility. These individuals had been living in facilities for an average of a little over 4 months at the time of application. About 90 percent—488 applicants—had total nonhousing resources of \$30,000 or less. (See fig. 3.) Eleven percent—59 applicants—did not have any nonhousing resources, while about 5 percent had total nonhousing resources of \$60,000 or more. For all applicants whose files we reviewed, median nonhousing resources were \$3,365.⁴⁰ Married applicants, who made up about 21 percent of the applicants, had higher

³⁹We were unable to obtain home values for about 18 percent of applicants (25 applicants) who reported owning homes. Therefore, for this analysis, we focused on total nonhousing resources—which include all resources except for the value of an applicant’s home—instead of total resources—which includes the home value. Total nonhousing resources include nonhousing resources that are counted and those that are generally not counted toward determining financial eligibility for Medicaid.

⁴⁰Mean (average) nonhousing resources were \$13,440, and ranged from \$0 to \$355,387.

median nonhousing resources (\$8,407) than single applicants.⁴¹ Of the single applicants, females, who made up approximately 65 percent of all applicants, had higher median nonhousing resources (\$3,109) than males (\$1,628), who made up about 14 percent of all applicants.

Figure 3: Distribution of Nonhousing Resources of Medicaid Applicants in Selected Counties in Three States



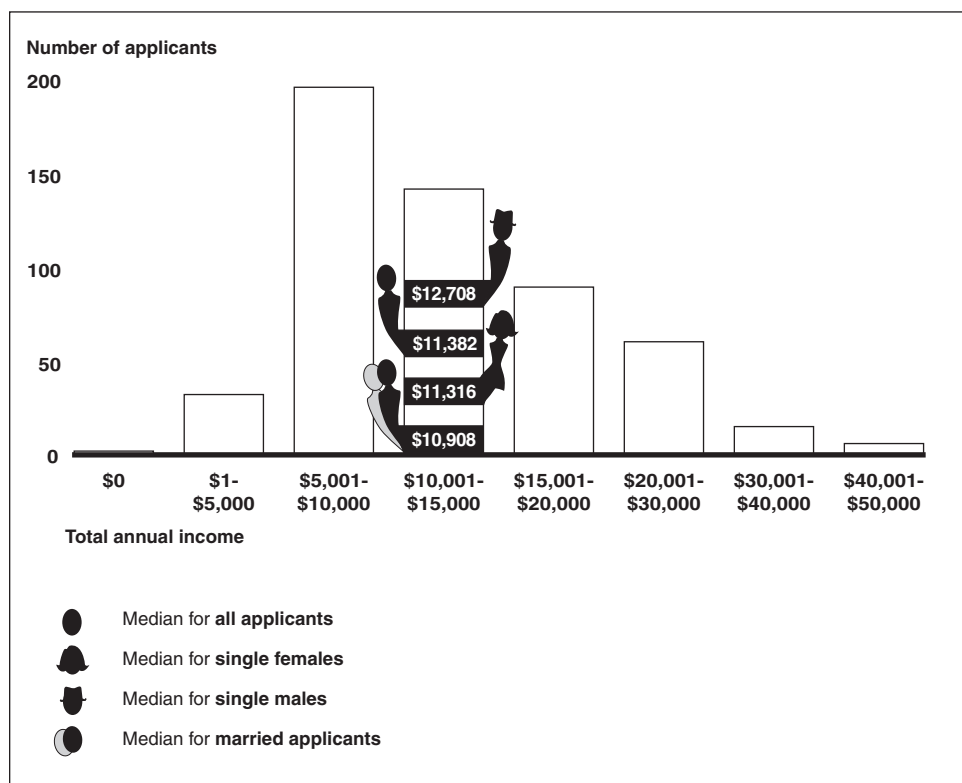
Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Note: For purposes of determining eligibility for Medicaid coverage for nursing home care, an applicant's resources are considered to be both those of the applicant and those of the spouse.

⁴¹For purposes of determining Medicaid eligibility, an applicant's resources are considered to be both those of the applicant and those of the spouse.

Eighty-five percent of the Medicaid applicants whose files we reviewed (459 applicants) had annual incomes of \$20,000 or less. The median annual income of all applicants was \$11,382.⁴² (See fig. 4.) Single male applicants generally had higher annual incomes than single females.

Figure 4: Distribution of Annual Income of Medicaid Applicants in Selected Counties in Three States



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Note: For purposes of determining eligibility for Medicaid coverage for nursing home care, only the income of an applicant is considered, regardless of the applicant's marital status.

⁴²Mean (average) annual income was \$13,083 and ranged from \$0 to \$47,316. All three states in which we reviewed applications have provisions that allow certain applicants to obtain Medicaid coverage for nursing home care even if their income exceeds the standards. For example, South Carolina requires such applicants to place excess income in an income trust, which is used to pay for the applicant's care. In addition, based on federal law, a portion of a married applicant's income may be contributed to the community spouse's minimum needs allowance, thereby decreasing the applicant's income stream.

Applicants had several different types of nonhousing resources, some of which were not counted toward determining eligibility for Medicaid coverage for nursing home care. For example, a little over half (53 percent) of all applicants whose files we reviewed had prepaid burial or funeral arrangements, with a median value of \$2,614. Additionally, about 38 percent of the applicants had life insurance. Whether the burial arrangements or life insurance policies counted toward determining Medicaid eligibility depended on their type and value as well as the state in which the applicant applied.⁴³

Of the 540 applicants whose files we reviewed, 137 applicants (25 percent) owned homes and 83 of the home owners (about 61 percent) were single. Based on the applications we reviewed, home ownership varied by state, with 32 percent of the applicants we reviewed in selected counties in South Carolina owning homes, compared with 28 percent and 16 percent in Pennsylvania and Maryland, respectively. For the 112 applicants in all selected counties for whom we were able to determine a value for their homes, the median value was \$52,954.⁴⁴

Most Medicaid Applicants Reviewed Were Approved upon Initial Application

About 76 percent of the Medicaid applicants whose files we reviewed were approved upon initial application (408 applicants), while 23 percent (122 applicants) were denied.⁴⁵ The majority of the approved applicants were single and female. Of the 122 applicants who were initially denied, 57 were approved upon submitting a subsequent application.⁴⁶ Therefore, 465 applicants, or 86 percent of all applicants whose files we reviewed,

⁴³For example, with regard to life insurance policies, Maryland and Pennsylvania do not count an applicant's life insurance policies if they have a combined face value of \$1,500 or less. If the policies have a combined face value of more than \$1,500, then Maryland counts the total cash value of the policies, while Pennsylvania counts the total cash value of the policies less \$1,000. South Carolina counts the total cash value of an applicant's life insurance policies if those policies have a combined face value of more than \$5,000.

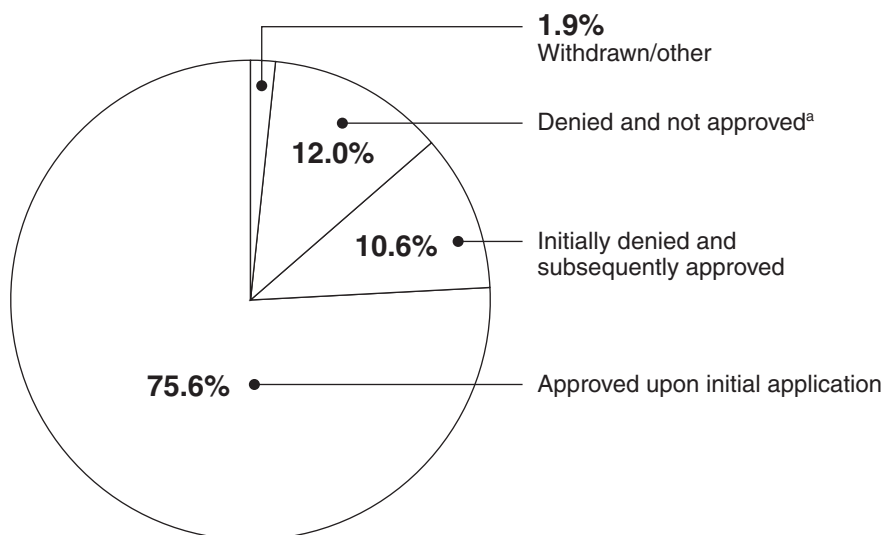
⁴⁴Mean home value was \$70,668 and ranged from less than zero to \$535,500. One applicant had a home valued at \$535,500 while the rest of the applicants had homes with values of \$358,600 or below. An applicant can have a home valued at less than zero if his or her debt is greater than the value of the home.

⁴⁵Two percent of the applicants withdrew their applications before receiving an eligibility determination. These percentages do not add to 100 because of rounding.

⁴⁶At the time of our application file reviews, 65 of the applicants whose initial applications were denied did not have a subsequent approved application in their files. We do not know if they submitted applications after the time of our review and were subsequently approved.

were eventually approved.⁴⁷ Figure 5 provides a breakdown of applicants by application status.

Figure 5: Percentage of All Applicants in Selected Counties in Three States, by Application Status (n=540)



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Note: Percentages do not add to 100 due to rounding.

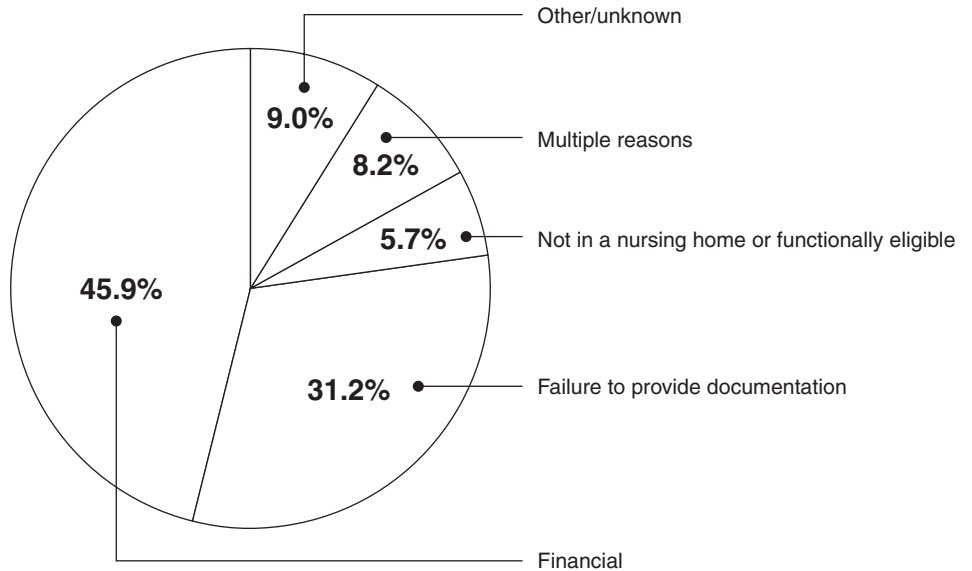
^aAt the time of our application file reviews, 65 of the applicants whose initial applications were denied did not have a subsequent approved application in their files. We do not know if they submitted applications after the time of our review and were subsequently approved.

Almost half of the denied applicants (56 of 122) were denied only for financial reasons—having income or resources that exceeded the standards, most having to do with resources exceeding the standards. For those applicants who were denied for having excess resources, their resources exceeded the standards by an average of \$25,116; the median amount of excess resources was \$13,260.⁴⁸ Other reasons for denial included failing to provide the requested documentation, not being in a nursing home or meeting functional eligibility criteria, or a combination of two or more of these reasons. (See fig. 6.)

⁴⁷The number of approved applicants varied by state. Specifically, of the files we reviewed, approximately 75 percent of applicants in South Carolina were approved, compared to 91 percent and 93 percent in Maryland and Pennsylvania, respectively.

⁴⁸The amount of these applicants' excess resources ranged from \$75 to \$205,440.

Figure 6: Percentage of Initially Denied Applicants in Selected Counties in Three States, by Reasons for Denial (n=122)



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Majority of Medicaid Applicants Reviewed Who Were Initially Denied Only for Financial Reasons Were Eventually Approved

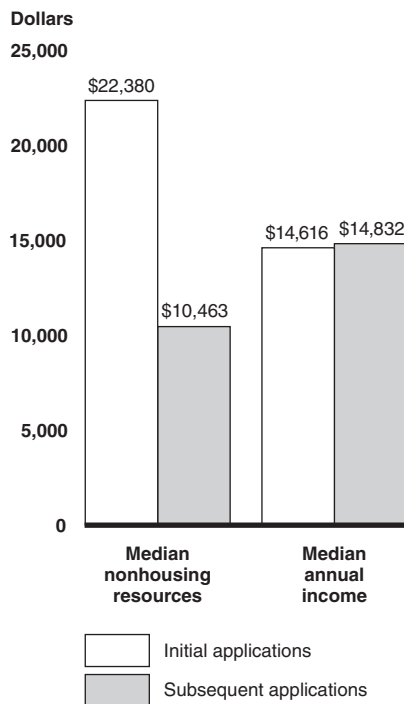
Of the 56 applicants who were initially denied only for financial reasons, 41 (73 percent) reapplied and were later approved. The time span between their initial and subsequent applications averaged a little over 5 months and ranged from less than 1 month to 31 months.

Of the 41 applicants who were initially denied only for financial reasons and were subsequently approved, their nonhousing resources generally decreased between the initial and subsequent applications, while their annual incomes stayed about the same. (See fig. 7.) Between the two applications, median nonhousing resources decreased from \$22,380 to \$10,463, with a maximum decrease of \$283,075. For most of these applicants, the overall decrease in nonhousing resources was specifically due to a decrease in financial holdings such as checking or savings accounts, stocks, and mutual funds.⁴⁹ For example, a married applicant initially applied and was denied for having countable resources that exceeded the state standards by \$51,213. The applicant applied again just

⁴⁹ Additionally, 9 of the 41 applicants owned homes at the time of their initial application; 2 of these applicants sold them prior to applying again.

over 9 months later and had resources within the state standards. Therefore, the applicant was approved.

Figure 7: Median Nonhousing Resources and Median Annual Income of Reviewed Applicants in Selected Counties in Three States Who Were Initially Denied Only for Financial Reasons and Subsequently Approved, at Time of Initial Application and Subsequent Application (n=41)



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Some of the files of applicants who were initially denied for financial reasons and were subsequently approved indicated that the applicants spent at least some of their resources on medical expenses or nursing home care, although this was not the case for all of them. In the files we reviewed for 13 of these applicants (32 percent), there were indications that the applicant had spent at least some of his or her resources on medical expenses, nursing home care, or both. For example, one applicant sold stock and received cash in exchange for a life insurance policy, spending about \$12,150 for 3 more months of nursing home care before being approved for Medicaid. In the remaining 28 applicants' files (68 percent), there was no indication that their resources were used for medical or nursing home care. For example, one married applicant was initially denied for having resources of \$205,440 above the state's standard.

The file indicated that when the applicant reapplied and was approved about 6 months later, \$140,000 of the applicant's resources was used to purchase an annuity to create an income stream for the community spouse, which was not counted toward the applicant's eligibility.⁵⁰

Few Transfers below FMV Identified for Applications Reviewed and Penalties Rarely Delayed Eligibility

Few of the approved applicants whose files we reviewed in selected counties in three states were found to have transferred assets for less than FMV during the 36-month look-back period,⁵¹ and those who did transfer assets for less than FMV rarely experienced a delay in eligibility for Medicaid coverage for nursing home care as a result.⁵² The proportion of approved applicants found to have transferred assets for less than FMV varied both within and among the three states, and the variation may be due, in part, to counties' or states' Medicaid application review procedures. At the time these applicants applied for Medicaid—state fiscal year 2005 or earlier—none of the three states reviewed imposed penalties for partial months, and the penalty period began at the time of the asset transfer; under these circumstances, only two of the applicants received a penalty that delayed their eligibility for Medicaid coverage for nursing home care as a result of transferring assets for less than FMV. The other applicants were either not assessed a penalty, because the penalty would have been for less than 1 month of coverage, or the penalty they were assessed had expired by the time they submitted their Medicaid application. Thus, these applicants did not experience a delay in their Medicaid coverage as a result of transferring assets for less than FMV. The total amount of assets transferred for less than FMV varied by applicant, as did the number of transfers each applicant made. In terms of the kinds of assets transferred for less than FMV, applicants most commonly transferred financial holdings such as cash or stocks, and their children or grandchildren were the most common recipients of the transfer.

⁵⁰The file did not indicate how the applicant spent the remaining \$65,440.

⁵¹Prior to the DRA, the look-back period for asset transfers was generally 36 months.

⁵²When discussing asset transfers for less than FMV, we are referring to transfers that the state determined would be subject to the penalty provisions. We are not referring to transfers that, under federal law, are exempt from the penalty provisions. Such exemptions include transfers of assets to the individual's spouse, transfers to another individual for the spouse's sole benefit, or transfers to a disabled child. Additionally, transfers do not result in a penalty period if the individual can show that the transfer was made exclusively for purposes other than qualifying for Medicaid.

Approximately 10 Percent of Approved Applicants Transferred Assets for Less than FMV

Of the 465 approved applicants whose files we reviewed from selected counties in three states, the files for 47 applicants (10 percent) indicated that the applicants had transferred assets for less than FMV during the 36-month look-back period.⁵³ The proportion of approved applicants found to have transferred assets for less than FMV varied both within and among the states reviewed, ranging from a high of approximately 24 percent of approved applicants in Orangeburg County, South Carolina, to a low of approximately 4 percent in Allegheny County, Pennsylvania (see table 6).

Table 6: Percentage of Approved Applicants Whose Files Indicated They Had Transferred Assets for Less than FMV, by State and Selected County

State	County	Approved applicants		
		Number who transferred assets for less than FMV	Total	Percentage who transferred assets for less than FMV
Maryland	Baltimore	11	57	19.3%
	Baltimore City	3	48	6.3
	Montgomery	3	58	5.2
	Subtotal	17	163	10.4
Pennsylvania	Allegheny	3	72	4.2
	Montgomery	3	30	10.0
	Philadelphia	3	65	4.6
	Subtotal	9	167	5.4
South Carolina	Charleston	9	46	19.6
	Greenville	8	72	11.1
	Orangeburg	4	17	23.5
	Subtotal	21	135	15.6
Total		47	465	10.1%

Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

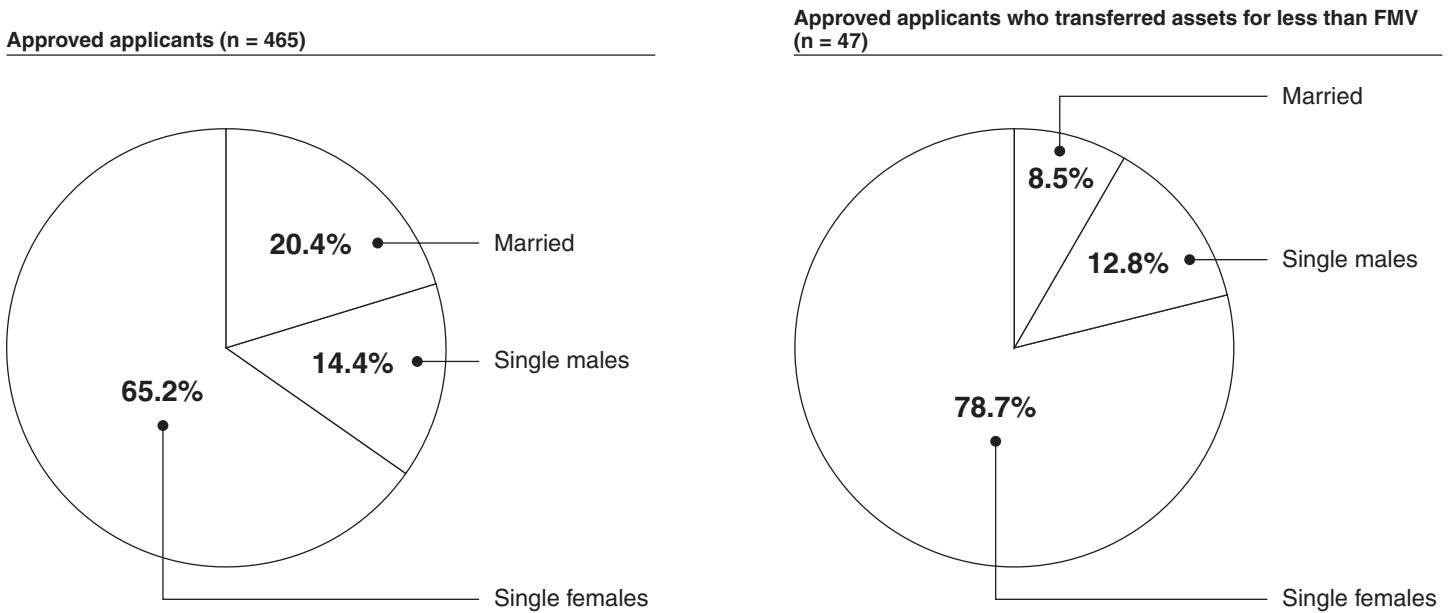
The variation in the proportion of applicants who were identified as having transferred assets for less than FMV may be due, in part, to states' ability to identify transfers not reported by the applicant. About half of the assets transferred for less than FMV by applicants in South Carolina were

⁵³Our analysis of asset transfers focused on applicants who were *approved* for Medicaid coverage, because if an applicant appears likely to be denied Medicaid coverage, states might not conduct a complete review to determine if an applicant transferred assets for less than FMV.

identified by the eligibility workers as opposed to being reported by an applicant. Eligibility workers in Maryland and Pennsylvania identified 9 percent and 4 percent of transfers, respectively.

The approved applicants who transferred assets for less than FMV were predominately single females. Although single females accounted for 65 percent of approved applicants, they accounted for over 78 percent of the approved applicants who transferred assets for less than FMV. (See fig. 8.) Additionally, 89 percent of approved applicants who transferred assets for less than FMV resided in a long-term care facility before applying for Medicaid. These individuals were in the facility for an average of over 5 months before they applied for Medicaid coverage.

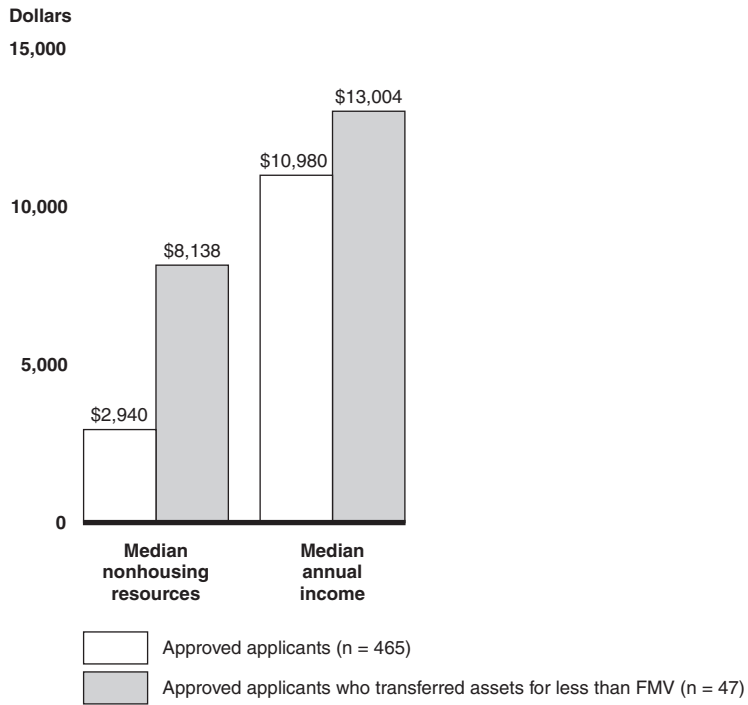
Figure 8: Percentage of Approved Applicants and Approved Applicants Who Transferred Assets for Less than FMV, by Gender and Marital Status



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Approved applicants who transferred assets for less than FMV were better off financially (i.e., they had higher income and resources), even after excluding the amount transferred, compared with the universe of approved applicants. For example, approved applicants who transferred assets had higher median nonhousing resources (\$8,138) compared with all approved applicants (\$2,940). (See fig. 9.)

Figure 9: Median Nonhousing Resources and Income for Approved Applicants and Approved Applicants Who Transferred Assets for Less than FMV



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Note: The amount of nonhousing resources for the approved applicants who transferred assets for less than FMV reflects the amount after excluding the assets transferred.

Transfers for Less than FMV Rarely Delayed Medicaid Eligibility

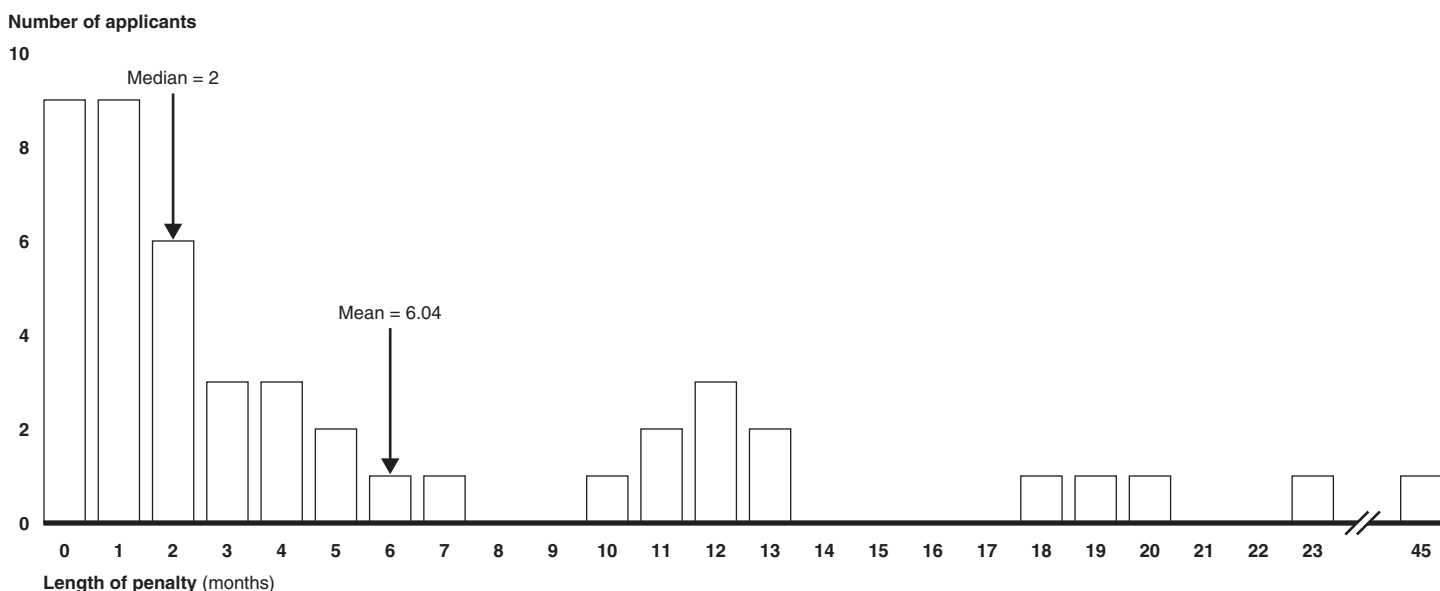
Transfers for less than FMV rarely led to delays in eligibility for Medicaid coverage for nursing home care, as most applicants' assessed penalty periods expired before they applied for Medicaid. Among the 47 approved applicants who transferred assets for less than FMV, the length of the penalty period assessed averaged about 6 months, with a median penalty period of 2 months. (See fig. 10.) At the time these applicants applied for Medicaid (state fiscal year 2005 or earlier), the three states in which we reviewed applications did not assess penalties for partial months; that is, the length of penalties assessed was rounded down to the closest whole month.⁵⁴ As a result, 9 of the 47 approved applicants who transferred

⁵⁴Pennsylvania began assessing partial-month penalties during its 2006 fiscal year, specifically in August 2005. With the passage of the DRA, all states are required to assess partial-month penalties.

assets for less than FMV (about 19 percent) were not assessed a penalty because they transferred assets valued at less than the cost of a month of nursing home coverage for a private-pay patient in their state.⁵⁵

Furthermore, because penalty periods began at approximately the date of the asset transfer, 36 applicants' penalty periods expired prior to the submission of their application for Medicaid coverage for nursing home care.⁵⁶ Thus, only 2 applicants experienced delays in Medicaid coverage resulting from their transfers of assets for less than FMV; the delays were for 1 and 6 months, respectively.

Figure 10: Distribution of 47 Approved Applicants Who Transferred Assets for Less than FMV, by Length of Assessed Penalty Periods, in Months



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

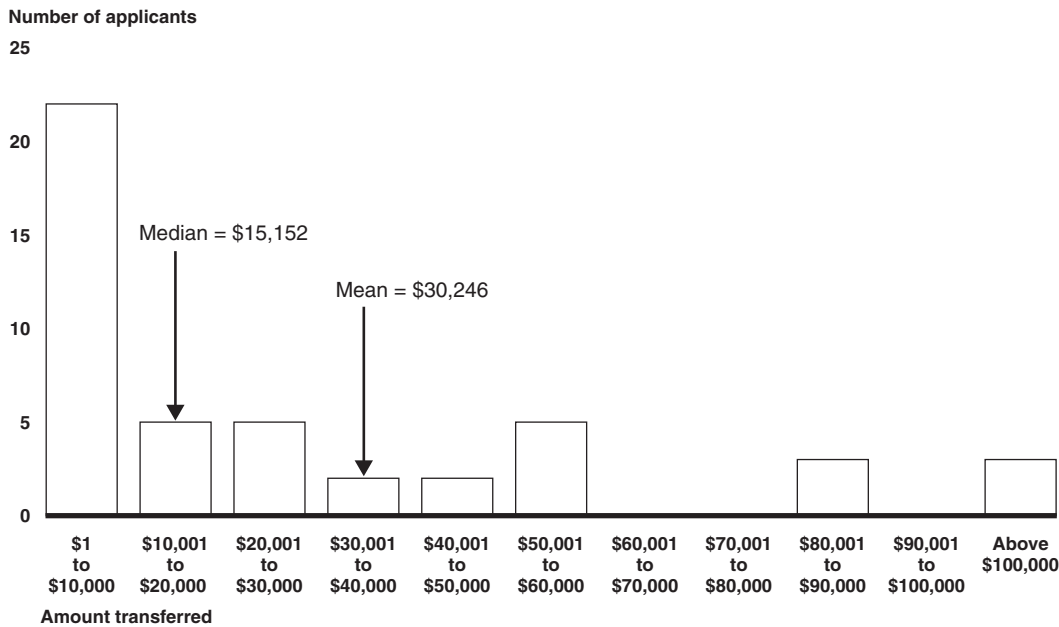
⁵⁵In state fiscal year 2005, the average monthly cost for a private-pay patient in a nursing facility—the figure used for calculating the penalty period—was \$4,300.00 in Maryland, \$5,787.38 in Pennsylvania, and \$4,234.00 in South Carolina.

⁵⁶The DRA changed the timing of the penalty period. For transfers made on or after February 8, 2006, the penalty period will begin on the later of (1) the first day of the month during or after which an individual transfers assets for less than FMV or (2) the date on which the individual is eligible for Medicaid and would otherwise be receiving coverage for long-term care services, were it not for ineligibility due to the imposition of the penalty period.

Amounts of Assets Transferred for Less than FMV Varied

Among those who transferred assets for less than FMV, the total amount of the assets transferred varied, with a median amount of \$15,152.⁵⁷ The applicant with the lowest total transfer amount made a onetime cash gift of \$1,000 to her child, while the applicant with the highest total transfer amount used funds from a trust established for her care to buy and resell property. Since the trust fund should have only been used for the applicant's care, the use of the funds to pay real estate fees, which totaled \$201,516, was considered a transfer of assets for less than FMV. Figure 11 shows the distribution of the amounts of transfers for less than FMV per approved applicant. Nearly half of the applicants who transferred assets for less than FMV (22 of 47) transferred \$10,000 or less; 10 of the 22 applicants transferred \$5,000 or less. In contrast, 6 of the 47 applicants (about 13 percent) transferred more than \$80,000 in assets.

Figure 11: Distribution of 47 Approved Applicants Who Transferred Assets for Less than FMV, by Amount Transferred

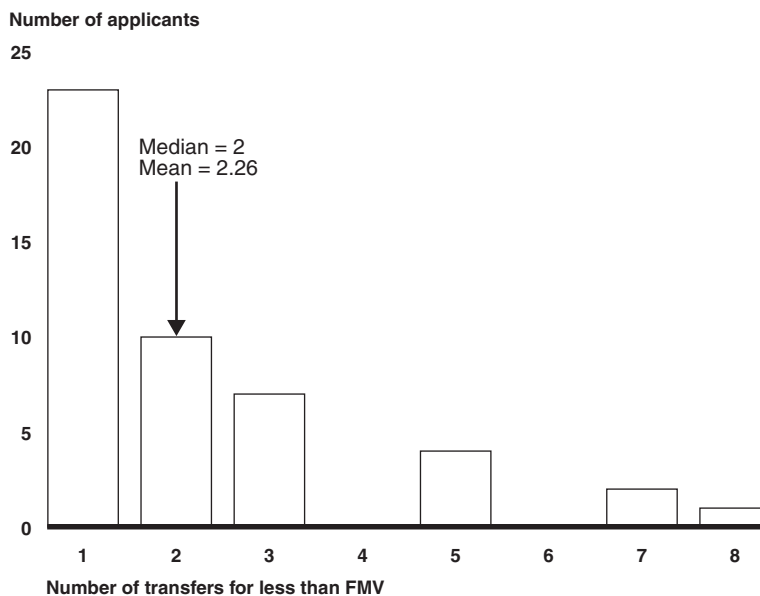


Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

⁵⁷The mean amount of all assets transferred for less than FMV was \$30,246 and ranged from \$1,000 to \$201,516.

The number of transfers for less than FMV made by applicants also varied, averaging slightly over two transfers per applicant. Specifically, 23 applicants made a single transfer and 1 applicant made eight transfers (see fig. 12). The eight transfers spanned a 1½-year period and ranged from an over \$4,000 cash gift to a grandchild to a stock transaction in which the applicant gave a relative over \$33,000 of her stock.

Figure 12: Distribution of 47 Approved Applicants Who Transferred Assets for Less than FMV, by Number of Transfers



Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

The majority of asset transfers for less than FMV (approximately 84 percent) involved the transferring of financial holdings such as cash or stocks. However, the types of assets transferred varied by state (see table 7). This variation may be related, in part, to differences in counties' or states' Medicaid application review procedures. Specifically, based on our review of the files, county officials in South Carolina conducted searches of real property tax databases, which likely allowed South Carolina eligibility workers to identify property transfers that were not reported by the applicant. For example, a South Carolina applicant was penalized because the eligibility worker identified that the applicant had transferred property for less than FMV—a house valued at \$84,700 to her son for \$5. In contrast, although Maryland eligibility workers could search the state's property tax records, state officials told us that workers' searching abilities were limited because they needed to know the county

and street name of the property. As a result, it likely would be difficult for Maryland eligibility workers to identify unreported transfers of property.

Table 7: Percentage of Assets Transferred for Less than FMV by Type of Asset for 47 Approved Applicants in Selected Counties in Three States

Asset type	Maryland	Pennsylvania	South Carolina	Total
Financial holdings ^a	95.5%	82.6%	71.8%	84.0%
Real property	0	4.4	25.6	10.4
Automobile	2.3	8.7	0	2.8
Other ^b	2.3	4.4	2.6	2.8

Source: GAO analysis of Medicaid nursing home application data from nine counties as of July 2006.

Note: Percentages may not add to 100 because of rounding.

^aFinancial holdings includes items such as cash or stocks.

^bIncludes instances where the type of asset transferred was unknown.

Applicants most frequently transferred assets to their children and grandchildren. Approximately 47 percent of transferred assets were given to children or grandchildren, 15 percent were given to other relatives, and 38 percent were given to other individuals.⁵⁸

Extent to Which Some DRA Long-Term Care Provisions May Affect Eligibility Is Uncertain

The extent to which some DRA long-term care provisions may affect applicants' eligibility for Medicaid coverage for long-term care is uncertain. Our review of a sample of Medicaid applications indicated that the DRA penalty period provisions could increase the likelihood that individuals who transfer assets for less than FMV on or after the date of enactment will experience a delay in eligibility for Medicaid coverage for long-term care. However, the extent of the delay is uncertain. The effects on eligibility of other DRA provisions—specifically those related to annuities, home equity, the allocation of assets to community spouses, and life estates—may be limited because they only apply to a few applicants, affect applicants in some states but not in others, or both.

⁵⁸“Other individuals” includes instances where the recipient of the transfer was unknown.

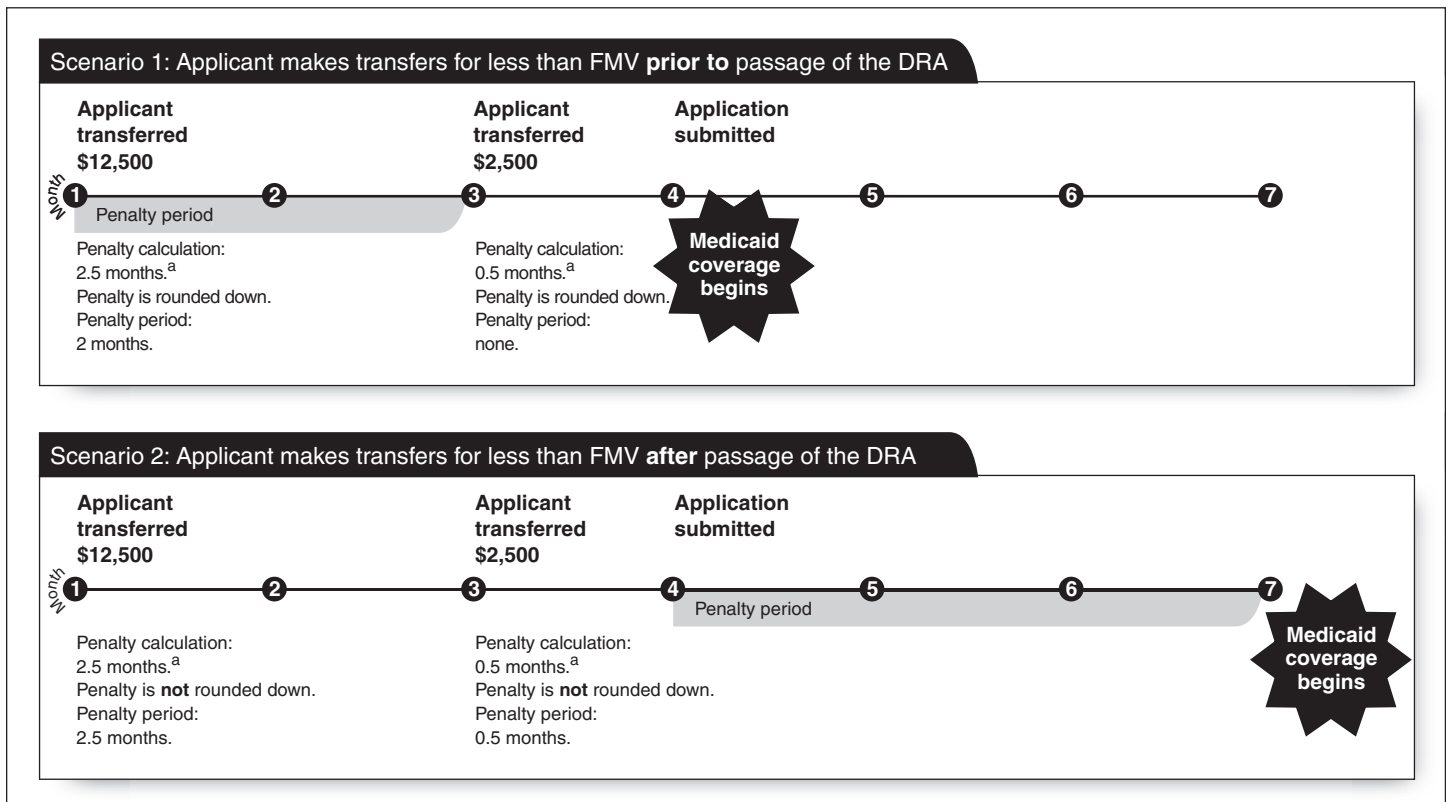
DRA Provisions Related to Penalty Periods Could Delay Eligibility for Those Who Transfer Assets for Less than FMV, but the Extent of the Delay Is Uncertain

The DRA requires states to change when a penalty period is applied and how it is calculated.⁵⁹ First, the DRA changes the beginning date of a penalty period from approximately the date of the transfer—which could precede the date of a Medicaid application by days, months, or years—to the later of (1) generally the first day of a month during or after which an asset has been transferred for less than FMV or (2) the date on which the individual is eligible for Medicaid and would otherwise be receiving coverage for long-term care services, were it not for ineligibility due to the imposition of the penalty period. All applicants who transfer assets for less than FMV during the look-back period on or after February 8, 2006 (the date the DRA was enacted) will experience a delay in eligibility for Medicaid coverage for long-term care, whereas before that date, some applicants' penalty periods expired before they applied for Medicaid coverage.⁶⁰ Second, regarding the calculation of the penalty period, the DRA prohibits states from “rounding down” or disregarding fractional periods of ineligibility when determining the penalty period. This provision could result in longer penalty periods for some applicants. (See fig. 13, which illustrates the potential effects of the DRA penalty period provisions.)

⁵⁹ Additionally, the DRA gives states the option of treating an applicant's total, cumulative value of all assets transferred for less than FMV as one transfer when determining the applicant's penalty period.

⁶⁰ The DRA provides that only transfers of assets made on or after February 8, 2006, are subject to the 60-month look-back period. Thus, transfers made prior to February 8, 2006, could result in a penalty period only if they occur within 36 months from the date an institutionalized person submitted an application. In contrast, transfers made on or after February 8, 2006, could result in a penalty period if they occur within 60 months of the date of application. Given this, as a practical matter, the look-back period will gradually increase from 36 to 60 months and will reach the full 60 months on February 8, 2011.

Figure 13: Example of How the DRA Penalty Period Provisions Could Delay Medicaid Eligibility for Applicants Who Transfer Assets for Less than FMV



Source: GAO.

^aThe penalty period is calculated by dividing the dollar amount of the assets transferred by the average monthly private-pay rate for nursing home care in the state (or the community, at the option of the state). In this example, we assumed that the average monthly private-pay rate for nursing home care was \$5,000.

If these DRA penalty period provisions had been in effect for the applicants whose files we reviewed, all 47 approved applicants who transferred assets for less than FMV would have experienced a delay in Medicaid coverage, compared with only 2 who actually experienced a delay. Additionally, the penalty period would have been longer for 45 of the 47 approved applicants. The increase in the penalty period would have ranged from less than 1 day to almost 6 months, with a median increase of about 2½ weeks. As a result, the median delay in eligibility would have

been approximately 3 months and ranged from about 1 week to over 47 months.⁶¹

An increase in the number of applicants whose eligibility is delayed may be mitigated by two factors. First, states may see an increase in the number of approved applicants seeking to waive their penalty periods because they would create an undue hardship—that is, the application of the penalty would deprive the applicants of (1) medical care that would endanger the applicants' health or life or (2) food, clothing, shelter, or other necessities of life.⁶² Officials from the three states in which we reviewed applications commented that they received few undue hardship requests prior to the DRA but expected to see an increase in requests as the DRA provisions are implemented. Second, the extent to which individuals are subject to penalty periods may change as individuals may make different decisions regarding the transferring of assets as a result of the DRA.

Other DRA Provisions May Have Limited Effects on Eligibility

The effects on eligibility for Medicaid coverage for long-term care of other DRA provisions may be limited. This is primarily because few Medicaid applicants appear to have resources that are specifically addressed by the DRA, namely annuities, home equity of more than \$500,000, or life estates. Additionally, the provision on allocating income and resources to the community spouse will only affect married applicants in certain states, thus limiting the effects that the DRA might have on eligibility.

- **Annuities.** The DRA added requirements for states regarding the treatment of annuities. A state must treat the purchase of an annuity as a transfer for less than FMV unless certain conditions, such as a requirement that the state be named as a remainder beneficiary, are met. However, the effect of this provision may be limited because few Medicaid applicants appear to have annuities. We found that 3 percent of the approved

⁶¹This analysis assumes the DRA penalty period provisions had been in effect at the time the applicants made the transfers. However, if an applicant transfers assets before the date of enactment, then the transfer will be subject to the rules for transfers before the DRA was enacted. In contrast, if an applicant transfers assets on or after the date of enactment, then the transfer will be subject to the DRA rules. If an applicant transfers assets both before and on or after the date of enactment, then the pre-DRA rules apply to the earlier transfer and the DRA rules apply to the latter.

⁶²Under the DRA, states are required to establish procedures to allow nursing homes (or other long-term care facilities) to file a request to waive a resident's penalty period if it would create an undue hardship for that resident.

applicants (14 of 465) whose application files we reviewed owned an annuity.⁶³ These 14 applicants' annuities would have been considered transfers for less than FMV under the DRA because they did not name the state as a remainder beneficiary, had a balloon payment, or both. While the incidence of annuities among Medicaid beneficiaries is not nationally known, a January 2005 study undertaken at the request of CMS estimated that, among the five states examined, the percentage of Medicaid long-term care beneficiaries who had an annuity ranged from less than 1 percent in two states to more than 3 percent in one state.⁶⁴

- **Home Equity.** Under the DRA, certain individuals with home equity greater than \$500,000 are not eligible for Medicaid payment for long-term care, including nursing home care.⁶⁵ The effect of this provision may be limited because it appears that few individuals who apply for Medicaid coverage for nursing home care have homes valued at more than \$500,000. For example, 23 percent of the 465 approved Medicaid nursing home applicants whose files we reviewed owned homes. Of the homes for which we could determine values, the median value was \$57,600.⁶⁶ Only one approved applicant owned a home valued at more than \$500,000. Although we do not know this applicant's equity interest in the home, the applicant would not have been subject to the DRA home equity provision, since the applicant's spouse lived in the home. Additionally, our review of 2004 HRS data indicated that no elderly nursing home residents owned a home valued at more than \$500,000.

⁶³ Among the approved applications we reviewed, there were eight applicants with annuities in Maryland, three in Pennsylvania, and three in South Carolina. We were unable to determine annuity values for one of the approved applicants who owned annuities. Of the annuities for which we could determine values, the median value was \$18,000, the mean value was \$77,073, and the values ranged from \$1,147 to \$565,000.

⁶⁴ See R.A. Levy et al., *Analysis of the Use of Annuities to Shelter Assets in State Medicaid Programs* (January 2005).

⁶⁵ An individual with equity in his or her home of greater than \$500,000 may still be eligible for Medicaid payment for long-term care if the individual has a spouse, child under age 21, or child who is considered blind or disabled living in the home. States have the option to increase the home equity limit up to \$750,000. As of summer 2006, all three of the states included in our review elected to keep the threshold at \$500,000.

⁶⁶ We were unable to determine home values for approximately 18 percent (19 of 108) of all approved applicants who owned homes. Of the homes for which we could determine values, the mean value was \$77,276 and the values ranged from \$200 to \$535,000. This analysis does not account for any debt that applicants may have on their homes.

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- **Life Estates.** The DRA requires states to treat the purchase of certain life estates as a transfer of assets for less than FMV unless the purchaser (the applicant) lived in the house for at least 1 year after the date of purchase.⁶⁷ The effect of this provision may be limited because we found that few approved Medicaid nursing home applicants whose files we reviewed had life estates. Specifically, the proportion of approved applicants who owned life estates ranged from zero in Pennsylvania to 2 percent in South Carolina.⁶⁸
 - **Income First.** The DRA's income-first provision has the potential to affect married applicants in states that did not already use the income-first methodology. Under the income-first methodology the difference between a community spouse's income and his or her minimum needs allowance is made up by transferring income from the institutionalized spouse. According to CMS, approximately half of all states did not use the income-first methodology before the passage of the DRA.⁶⁹ Of the three states we reviewed, only Pennsylvania will be affected by this provision.⁷⁰ Among approved applicants in Pennsylvania, 6 of the 42 married applicants whose files we reviewed would have been affected by this change because these applicants had retained resources in excess of the standards to create income streams for their community spouses. Specifically, they created annuities for the community spouses with values ranging from \$7,372 to \$77,531, with a median value of \$39,912. Pennsylvania officials told us that almost all institutionalized spouses in their state have enough income to supplement the income needs of their community spouses. As a result, under the DRA, applicants would not be allowed to retain resources in excess of the standards as they had previously through the creation of annuities. Rather, resources in excess of those allowed by the Medicaid program would need to be reduced in order for the institutionalized spouse to be eligible for Medicaid.

⁶⁷ A life estate is an interest in real property that gives the owner of the interest the right to use and possess the property only for the duration of the life of a person, usually the person who occupies the premises.

⁶⁸ We were not able to assess whether the DRA provision on the treatment of life estates would apply to the life estates that these approved applicants had.

⁶⁹ These data are based on a telephone survey conducted by CMS in 2001.

⁷⁰ Before enactment of the DRA, Pennsylvania allowed married applicants to allocate resources to the community spouse before allocating the institutionalized spouse's income. The other two states, Maryland and South Carolina, already used the income-first methodology.

Agency and State Comments and Our Evaluation

We provided copies of a draft of this report to CMS and the three states in which we reviewed Medicaid nursing home application files: Maryland, Pennsylvania and South Carolina. We received written comments from CMS (see app. II) and South Carolina (see app. III). Maryland provided comments via e-mail, while Pennsylvania did not comment on the draft report.

In its written comments, CMS generally agreed with our findings, but noted the limited number of states in which we reviewed applications and that study was done before the effects of the DRA could be assessed. We agree that the actual effects of the DRA are not yet known. However, our findings based on applications submitted prior to the implementation of the DRA provide insight into what its effects may be. CMS also commented that the DRA will be working as Congress intended if applicants experience delays in Medicaid eligibility as a result of transferring assets for less than FMV.

Maryland and South Carolina generally agreed with our findings. In addition, Maryland emphasized the difficulties faced by Maryland eligibility workers in identifying unreported transfers of assets due to their limited ability to search the state's property tax records. South Carolina highlighted our finding that 15.6 percent of the approved applicants whose files we reviewed in South Carolina were found to have transferred assets for less than FMV, as compared to 10.4 percent and 5.4 percent in the other two selected states. The state attributed this difference to the effectiveness of South Carolina's eligibility process and its training of eligibility workers to enable them to identify transfers of assets not reported by an applicant. In response to our finding that only 2 of the 47 approved applicants who transferred assets for less than FMV experienced a delay in Medicaid eligibility as a result of transferring assets, South Carolina recommended that we clarify that this occurred despite the fact that the states were adhering to federal requirements. We did not make a change, as we believe the report clearly states why the other applicants did not experience a delay in Medicaid eligibility.

Technical comments from CMS were incorporated into the report as appropriate.

As agreed with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Administrator of the Centers for Medicare & Medicaid Services. We will also provide copies to others upon request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7118 or allenk@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 major contributions to this report are listed in appendix IV.



Kathryn G. Allen
Director, Health Care

Appendix I: Scope and Methodology

To examine the financial characteristics of elderly nursing home residents nationwide, including the extent to which they transferred cash, we analyzed data from the Health and Retirement Survey (HRS). HRS is a longitudinal national panel survey of individuals over age 50 sponsored by the National Institute on Aging and conducted by the University of Michigan. HRS includes individuals who were not institutionalized at the time of the initial interview and tracks these individuals over time, regardless of whether they enter an institution. Researchers conducted the initial interviews in 1992 in respondents' homes and follow-up interviews over the telephone every second year thereafter.¹ HRS questions pertain to physical and mental health status, insurance coverage, financial status, family support systems, employment status, and retirement planning.²

For this analysis, we used HRS data from 1992 to 2004.³ We limited our analysis to elderly nursing home residents who had been surveyed at least once before they entered a nursing home. We defined an elderly individual as anyone 65 years of age or older. On the basis of individuals' answers on HRS, we defined a nursing home resident as anyone who met one of the following three criteria:

1. answered "yes" to permanently living in a nursing home;
2. answered "no" to permanently living in a nursing home but spent more than 360 nights in a nursing home; or
3. answered "no" to permanently living in a nursing home but spent 180 to 360 days in one and
 - a. died in a later survey period;
 - b. had three or more limitations in activities of daily living (ADL); or

¹HRS defines each 2-year survey period as a wave. Each wave corresponds to the second year of a survey period in which the survey was conducted (wave one—1992—up to wave seven—2004).

²For more information about HRS, see <http://hrsonline.isr.umich.edu/> (accessed on Dec. 8, 2006).

³Since the data from this analysis are from multiple years, we converted all dollar figures into 2004 dollars, using the current methods series of the Consumer Price Index (CPI) for all urban consumers.

- c. had cancer, lung disease, or heart disease and some difficulty (rating of three or more) with mobility.⁴

We used the HRS data from the 1,296 individuals who met these criteria; this sample represented a population of 4,217,795 individuals. From these data, we estimated the financial characteristics of elderly nursing home residents as well as the percentage of residents who transferred cash or deeds to their homes, the amount transferred, and whether it varied by how they paid for their care (i.e., Medicaid-covered or non-Medicaid-covered).⁵ This analysis underestimates the percentage of elderly households that transferred assets and the amount of assets transferred because HRS data included only transfers of cash and deeds to the home. Additionally, HRS does not assess whether the transfers relate to individuals' attempts to qualify for Medicaid coverage for nursing home services.

In order to assess the reliability of the HRS data, we reviewed related documentation regarding the survey and its methods of administration. We also conducted electronic data tests to determine whether there were missing data or obvious errors. On the basis of this review, we determined that the data were sufficiently reliable for our purposes.

To analyze the demographic and financial characteristics of elderly individuals who applied for Medicaid coverage for nursing homes and if they applied more than once, as well as the extent to which they transferred assets for less than fair market value (FMV) and were subject to penalty periods, we reviewed Medicaid eligibility determination practices and Medicaid nursing home application files in three states. To select states, we assessed the ranking of five factors for each of the 51 states.

1. The percentage of the population aged 65 and over, which we determined using 2000 census data from the U.S. Census Bureau.

⁴Mobility is a summary index using five limitations: walking one block, walking several blocks, walking across a room, climbing one flight of stairs, and climbing several flights of stairs. The mobility rating is on a scale of zero (no difficulty or limitations with summary measurements) to five (some difficulty or limitation in all five summary measurements).

⁵Payer source for non-Medicaid-covered residents could include self-pay, Medicare, or other third-party insurance.

2. The cost of a nursing home stay for a private room for a private-pay patient based on data from a 2004 survey conducted for the MetLife Company.
3. The proportion of elderly (aged 65 and over) with incomes at or above 250 percent of the U.S. poverty level, which was based on information from the U.S. Census Bureau using the 2000 and 2002 Current Population Surveys.
4. The extent of Medicaid nursing home expenditures as reported by states to the Centers for Medicare & Medicaid Services (CMS).⁶
5. The availability of legal services specifically to meet the needs of the elderly and disabled, based on membership data from the National Academy of Elder Law Attorneys.

For each factor, we ranked the states from low to high (1 to 51) and then summed the five rankings for each state. On the basis of these sums, we grouped the states into three clusters (low, medium, and high), using natural breaks in the data as parameters (see table 8).

Table 8: Clusters Used for State Sample Selection

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

Sources: GAO analysis of data from the U.S. Census Bureau, CMS, the MetLife Market Survey of Nursing Home & Home Care Costs, and the National Association of Elder Law Attorneys.

We judgmentally selected one state from each cluster. In making this selection, we excluded some states, such as states that did not have the technical ability to generate the data needed to select Medicaid nursing

⁶Each quarter, states submit Medicaid program expenditures to CMS using the CMS-64 form. Our analysis used fiscal year 2000 nursing home expenditures as reported on the CMS-64.

home application files for review. The states we selected were South Carolina (low), Maryland (medium), and Pennsylvania (high).

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

1. Number of individuals aged 65 and over who applied for, or were enrolled in, Medicaid coverage for nursing home services.⁷
2. Number of licensed nursing home beds.⁸
3. Population aged 65 and over.⁹
4. Median and range of household income.¹⁰

For the first three factors, we ranked the counties within each selected state from high to low. Separately, we ranked the counties by median household income and split them into low, medium, and high groups, using natural breaks in the data as parameters. Of the counties that appeared in the top 10 ranking of each of the first three factors, we matched them with their respective median household income groups. Based on this assessment, we chose a county from each median household income group for each of the three states (see table 9).

⁷To select counties, we used information sent from state officials in the three states. For Maryland and Pennsylvania, we used data on the number of applicants, while for South Carolina we used data on the number of enrollees.

⁸We used information from the Medicare Nursing Home Compare Web site, <http://www.medicare.gov/NHCompare/Include/DataSection/Questions/SearchCriteria.asp>, for Pennsylvania (accessed on Apr. 24, 2006) and South Carolina (accessed on Apr. 24, 2006), and the “Long Term Care in Maryland: A Pocket Chartbook, 2005” (Baltimore, Md.: Maryland Health Care Commission, June 2005), http://mhcc.maryland.gov/longtermcare/_longtermcare.htm (accessed on Mar. 10, 2006) for Maryland.

⁹We used information from J. Billings and R.M. Weinick, *Monitoring the Health Care Safety Net—Book II* (Rockville, Md.: Agency for Healthcare Research and Quality, 2003), 334-336 for Pennsylvania; Billings and Weinick, *Monitoring the Health Care Safety Net—Book II*, 320-321, and the Maryland Association of Counties Web site, www.mdcounties.org/counties/demographics.cfm (accessed on Mar. 22, 2006) for Maryland; and Billings and Weinick, *Monitoring the Health Care Safety Net—Book II*, 336-337, and the U.S. Census Bureau (2004 estimates) for South Carolina.

¹⁰We used Billings and Weinick, *Monitoring the Health Care Safety Net—Book II*, 532-534 for Pennsylvania, 518-519 for Maryland, and 534-535 for South Carolina.

Table 9: Selected States and Counties, by County-Level Median Household Income Group

County-level median household income group	Selected states and counties		
	South Carolina	Maryland	Pennsylvania
Low	Orangeburg	Baltimore City	Philadelphia
Medium	Charleston	Baltimore	Allegheny
High	Greenville	Montgomery	Montgomery

Source: GAO.

We reviewed a total of 180 nursing home application files in each selected state, for a total of 540 files. Within each selected state, we based the number of application files reviewed in each county on the proportion of the county’s population of individuals aged 65 and over. (See table 10.)

Table 10: Number of Files Reviewed, by Selected State and County

Selected state	Selected county	Number of files reviewed
South Carolina	Orangeburg	22
	Charleston	72
	Greenville	86
	Total	180
Maryland	Baltimore City	51
	Baltimore	68
	Montgomery	61
	Total	180
Pennsylvania	Philadelphia	70
	Allegheny	74
	Montgomery	36
	Total	180
Total		540

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 state fiscal year 2005. These lists also included individuals who applied in previous years but whose files had activity during fiscal year

2005.¹¹ For example, an individual may have applied in state fiscal year 2004, but had his or her application approved in state fiscal year 2005. From the lists provided by the states, we randomly selected application files by unique identifying numbers. In order to compensate for application files that would need to be skipped because they did not meet our criteria or lacked adequate information, we requested additional files (10 to 15 percent) in each county. Therefore, when we determined that an application file was unusable, we included the next application file on our randomly generated list.

We established a file review protocol whereby we reviewed and recorded the earliest Medicaid application for nursing home services in each file regardless of the date of the application. If the earliest application was denied, then we recorded data from that application as well as data from the earliest subsequently approved application, if there was one. From each application, we collected and analyzed data on the applicants' demographic characteristics, income, nonhousing resources, and home value. We also collected and analyzed data on the number of applicants who transferred assets for less than FMV and the amount they transferred.

Since the selected counties used the information in these application files to determine eligibility for Medicaid coverage for nursing home services, 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 a total verification of at least 20 percent of entries. Additionally, we conducted electronic tests of the data collected to determine whether there were missing data or 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—housing and nonhousing resources. Based on these procedures, we determined that the data were sufficiently reliable. Moreover, these data can be generalized to the individual county level but cannot be generalized to the state or national level.

¹¹Therefore, the actual dates of the applications we analyzed ranged from March 1989 to April 2006. Ninety-nine percent of the applications we analyzed were from 2000 or later.

To assess the potential effect of provisions of the DRA, we used (1) HRS data and (2) data from our application file reviews. Specifically, we used 2004 HRS data to identify the number of elderly individuals in nursing homes who had houses in excess of \$500,000 and could be affected by the DRA home equity provision.¹² Additionally, we used the data from our review of Medicaid application files in three counties in each of the three states to analyze the potential effects of the DRA provisions pertaining to penalty periods, annuities, home equity, and income-first.

We performed our work from October 2005 through January 2007 in accordance with generally accepted government auditing standards.

¹²The data collection period for the 2004 HRS data was March 2004 to February 2005. The data we used were from a sample of 11,114 individuals that represented a population of 20,179,826 individuals.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

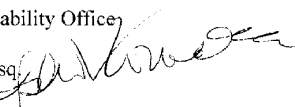
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

MAR - 6 2007

DATE:

TO: Kathryn G. Allen
Director, Health Care
Government Accountability Office

FROM: Leslie V. Norwalk, Esq. 
Acting Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Government Accountability Office (GAO) Draft Report: "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)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above-mentioned GAO draft report. Below are the technical changes that CMS would like to suggest be made to the GAO draft report.

The CMS does not disagree with the findings in this report, although we note that the number of States surveyed is very limited, and the study was done before the effects of the new Deficit Reduction Act of 2005 (DRA) transfer of assets provisions could be accurately measured.

The GAO observed that "Primarily because DRA changed the beginning date of the penalty period, there is an increased likelihood that applicants who transfer assets for less than FMV will experience delays in Medicaid eligibility." We wish to point out that if transfers of assets for less than FMV occur, and applicants experience delays in Medicaid eligibility as a result, this is exactly what Congress intended in enacting the DRA provision and the law will be working as intended.

In an effort to make the report more technically accurate, though, we would like to offer the following edits:

Page 2 – In the first paragraph, the discussion of "assets" for Medicaid eligibility purposes is not technically correct. We recommend rewriting the second and third sentences to read as follows: To meet the financial eligibility criteria, individuals must have ~~assets—both~~ income and resources— that fall below established standards, which vary by State but are within standards set by the Federal Government. Not all ~~assets—resources~~

Appendix II: Comments from the Centers for Medicare & Medicaid Services

Page 2 – Kathryn G. Allen

are counted in determining financial eligibility for Medicaid. In conformance with this change, we suggest that footnote 5 should be moved to follow the last sentence of the paragraph. The text of the footnote should be revised to include the following phrase at the beginning of the footnote and prior to the word “Assets”: “For purposes of determining whether a transfer of assets has occurred...”

Page 2 – In footnote 5, the first sentence, the word “clothing” should be deleted.

Page 8 – In footnote 16, the second sentence should read: “Under Section 1902(f) of the Social Security Act, States may use more restrictive Medicaid eligibility standards than they had in place in 1972 rather than rules that would otherwise apply under the Supplemental Security Income (SSI) program.”

Page 9 – Under the heading: Financial Eligibility for Medicaid Coverage for Long-Term Care - #3 – “SSI benefit (\$1,869 per month in 2007).”

Page 9 – In footnote 17, the word “countable” should be deleted.

Page 10 – Under the heading: Table 1: Types of Assets and Examples - footnote a, second and third sentences should read: “For example, an annuity is a financial instrument that provides income over a defined period of time for an initial payment of principal. The principal of an annuity may be considered a resource, while the payments it generates are considered income.”

Page 10 – Under the heading: Table 2: Income and Resource Standards for Selected Ways of Becoming Eligible for Medicaid, as of 2007 – in table heading: Income standard should read: “Less than \$623 per month for an individual and less than \$934 per month for a couple.” In the fourth cell in the same column, change the \$1,737 per month to \$1,869 per month. Footnote at the bottom of the page should read: “Under Section 1902(f) of the Social Security Act, States may use more restrictive Medicaid eligibility standards than they had in place in 1972 rather than Federal SSI rules.”

Page 11 – Under the heading: Spousal Impoverishment Protections - Income. The last sentence should read: “Prior to the DRA, if the community spouse’s income was less than the minimum needs allowance, then States could allow the difference to be made up in one of two ways: by requiring the transfer of income from the institutionalized spouse before additional resources were allocated (called the “income-first” approach) or by allowing the...” In footnote 20, change the year to 2007 and change the Federal maximum to \$101,640. In footnote 21, change the year to 2007 and the Federal minimum to

Now footnote 17 on p. 9.

Now footnote 19.

Now on p. 11.

Now on p. 12.

Now footnotes 22 and 23.

**Appendix II: Comments from the Centers for
Medicare & Medicaid Services**

Now footnote 26.

Page 3 – Kathryn G. Allen

\$20,328. In footnote 24, change the date to January 1, 2007, and the allowance can be no lower than \$1,650.00 and no higher than \$2,541.00.

Now footnote 27 on p. 12
and footnote 29 on p. 13.

Page 12–Continuation of the last sentence on page 11 should read – “community spouse to keep resources above the community spouse resource allowance, without regard to whether the institutionalized spouse had transferred as much income as possible to the community spouse, so that the additional resources could be used to generate more income (the “resource-first” approach).” Delete footnote 25. In footnote 27 – should read: “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 a similar institution or certain recipients of home and community-based services. States have the option to apply...”

Appendix III: Comments from the State of South Carolina Department of Health and Human Services



State of South Carolina Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

February 9, 2007

Ms. Carolyn Yocom
Assistant Director
US Government Accountability Office
Washington, DC 20548

RE: GAO-07-280 Medicaid and Asset Transfers

Dear Ms. Yocom:

Thank you for the opportunity to comment on your draft report titled *MEDICAID LONG-TERM CARE: Few Transferred Assets before Applying for Nursing Home Coverage; Impact of the Deficit Reduction Act on Eligibility is Uncertain*. In general the South Carolina Department of Health and Human Services agrees with your findings and conclusions. We would like to emphasize certain aspects of your review, which are critical to understanding the complex issues surrounding long term care for Medicaid beneficiaries. It is important that the GAO communicate these issues to Congress to consider as it looks for ways to improve the Medicaid program.

- It comes as no surprise that the GAO finds that the overwhelming majority (90%) of the individuals receiving Medicaid for long term care lack the resources to pay for their care, and therefore, the Medicaid benefit is going to those who are truly eligible. Your report finds little basis for the implication that people with substantial incomes and/or assets are becoming eligible for Medicaid funded nursing home care by improperly transferring these resources.
- Consequently, as you conclude, the extent to which the new long-term care provisions in the DRA may affect applicants' eligibility for Medicaid coverage for long-term care is uncertain. Even with a longer "look-back" period and the greater likelihood of a penalty for transferring assets at less than fair market value (FMV), the impact of the DRA on long-term care costs may be immaterial.

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**Appendix III: Comments from the State
of South Carolina Department of Health and
Human Services**

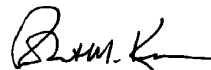
Ms. Carolyn Yocom
February 9, 2007
Page 2

As your report points out, if the DRA penalty period provisions had been in effect for the sample of applications you reviewed, the net result would have been a median delay of only three months for Medicaid eligibility for those who transferred assets at less than FMV.

- The report states that of the 47 approved applicants (in the sample for the three States) who transferred assets for less than FMV, only two of the applicants experienced a delay in Medicaid eligibility as a result. To an unsuspecting reader, it may appear that the States failed to impose a penalty, when in fact all federal requirements had been followed. Penalties were not assessed because it would have been for less than one month, or the penalty period had expired by the time the Medicaid application was submitted. We recommend that you strengthen this section of the report to clarify that the penalty provisions in effect at the time were, in fact, followed.
- Finally, the draft report found that of the 135 beneficiary records sampled in South Carolina, 21 or 15.6% had transferred assets for less than FMV, compared to 5.4% and 10.4% in the other States surveyed. We unequivocally believe that the difference is due to South Carolina's ability to identify transfers not reported by the applicant. We have worked diligently to develop an effective eligibility process and to improve training for eligibility workers so they know how to ask the right questions and research each applicant. This kind of due diligence on the part of States will continue to play a vital role in ensuring that Medicaid benefits are used appropriately and effectively.

Once again, we appreciate the hard work you put into this report, and we thank you for taking our comments under consideration.

Sincerely,



Robert M. Kerr
Director

RMK/ssb

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Kathryn G. Allen (202) 512-7118 or allenk@gao.gov

Acknowledgments

In addition to the contact named above Carolyn Yocom, Assistant Director; Kaycee Misiewicz Glavich; Grace Materon; Kevin Milne; Elizabeth T. Morrison; Daniel Ries; Michelle Rosenberg; Laurie Fletcher Thurber; and Suzanne M. Worth made key contributions to this report.

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