

**Joint Legislative Audit and Review Commission**

**The Virginia General Assembly**

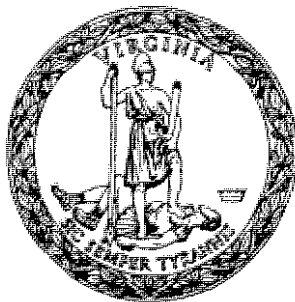
**Medicaid Asset Transfers  
and Estate Recovery**

**A Report in a Series  
on the Virginia Medicaid Program**

**REPORT OF THE  
JOINT LEGISLATIVE  
AUDIT AND REVIEW COMMISSION**

# **Medicaid Asset Transfers and Estate Recovery**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



## **SENATE DOCUMENT NO. 10**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1993**

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## Preface

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Senate Joint Resolution 91, passed during the 1991 legislative session requested the Joint Legislative Audit and Review Commission (JLARC) to work with the Joint Commission on Health Care to determine the extent to which Medicaid applicants use asset transfers to qualify for nursing home benefits. In addition, the need for establishing an estate recovery program was examined.

Concerns about asset transfers and estate recovery have been generated by the growing costs of Medicaid-funded nursing home care and anecdotal information suggesting that some program beneficiaries are giving away assets in order to qualify for this benefit.

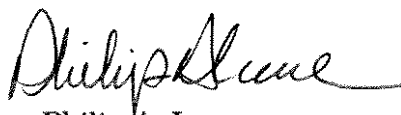
Currently, the Virginia Medicaid program is the largest of the State's health care programs for persons who are poor. In FY 1991, total expenditures for the program exceeded \$1.2 billion. Although nursing home benefits are provided to less than seven percent of the total number of eligible recipients, they account for more than one quarter — \$312 million — of total program spending.

This study found that a small proportion of Virginia's Medicaid applicants do take advantage of loopholes in the federal law to shift the costs of their care to the taxpayer while preserving assets for their heirs. More than \$14 million in assets were sheltered in this manner during fiscal year 1991. If federal and State laws are not adopted to discourage these practices, the number of persons who transfer assets with the intent of qualifying for Medicaid nursing home benefits could grow significantly, especially with the State's growing elderly population.

One strategy that can be used to defray a portion of the expenditures on nursing home care is an estate recovery program. Such a program would allow the State to recover some of the costs of nursing home care from persons who have property at the time they are terminated from Medicaid. This amounts to about \$9 million annually.

The results of JLARC staff's analysis show that 16 percent of the Medicaid recipients terminated from nursing homes in Virginia own property. It appears that as much as two-thirds of the cost of providing nursing home care to these people could be recouped through estate recovery.

On behalf of the Commission staff, I wish to acknowledge the support and cooperation by staff at the Department of Medical Assistance Services and the Department of Social Services in the preparation of this report.



Philip A. Leone  
Director

November 24, 1992

# JLARC Report Summary

## MEDICAID ASSET TRANSFERS AND ESTATE RECOVERY

November 1992

Joint Legislative  
Audit and Review  
Commission

A Report in a Series  
on the Virginia Medicaid Program

The Virginia Medicaid program is the largest of the State's health care programs for persons who are poor. In FY 1991, total expenditures for the program exceeded \$1.2 billion. In Virginia, one of the major and most expensive benefits provided by Medicaid is nursing home care. Although these benefits are provided to less than seven percent of the total number of eligible recipients, they account for more than one quarter — \$312 million — of total program spending.

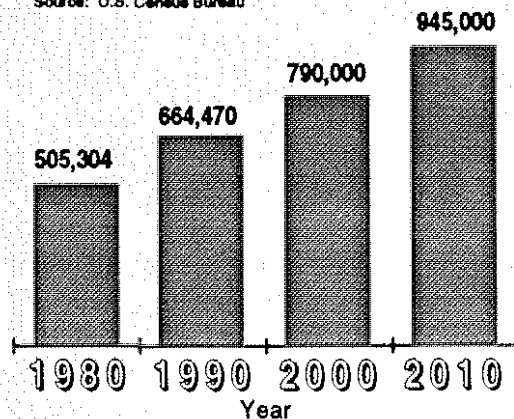
Because of the cost of nursing home care and the general absence of other third party payors, there is a growing concern that many middle- and upper-income residents are transferring their assets to qualify for Medicaid. There is also a concern that if federal and State laws are not adopted to limit this practice, the number of persons who transfer assets with the intent to qualify for Medicaid nursing home benefits could grow significantly.

The potential for an increase in costs for the Medicaid program is further heightened by the growing portion of the population in need of nursing home care, as shown in the graph below. As the elderly become a larger proportion of the population in Virginia, the State's exposure to financial responsibility for long-term care will increase.

In response to these concerns, Senate Joint Resolution 91 was passed during the 1991 session of the General Assembly. This mandate requires JLARC to work with the Joint Commission on Health Care to determine the extent to which Medicaid applicants use asset transfers to qualify for nursing home benefits. In addition to this issue,

### Projected Growth of Virginia's Elderly Population (65 and Over)

Source: U.S. Census Bureau



JLARC staff examined the extent to which Virginia could defray the cost of Medicaid nursing home spending by establishing a formal estate recovery program.

Several actions are recommended which would limit the use of asset transfers in Virginia. A more proactive estate recovery program is also proposed. These modest changes would not eliminate benefits for significant numbers of potentially eligible applicants because relatively small numbers of applicants appear to use asset transfer techniques. Therefore, it may be advantageous for the General Assembly to enact limitations now, when the number of potentially affected applicants is still small.

### **Medicaid Is the Primary Source of Funding for Nursing Home Care**

In 1990, there were more than 240 nursing homes in Virginia. Combined, these facilities provided in excess of 10 million days of care. Medicaid paid for almost 60 percent of these days. The second largest payment source was the private income and resources of uninsured nursing home residents (35 percent). Medicare (2 percent) and private insurance companies (3 percent) paid for considerably smaller amounts of the State's nursing home services.

### **Federal Law Allows Medicaid Recipients To Retain Significant Resources**

In order to be eligible for Medicaid nursing home benefits in Virginia, an applicant's monthly income must be less than the private cost of nursing home care and the total value of the applicant's countable resources cannot exceed \$2,000. However, when determining whether an individual meets Medicaid resource standards, federal law requires states to temporarily exclude the applicant's primary residence and permanently exempt any other resource that is not available to pay for care. This includes resources which the applicant previously owned but has given away through irrevocable, non-discretionary trusts. It may also include any property in which the applicant has only a life interest — the right to use the property while they are alive.

Due to these federal resource exemptions, 37 percent of the new Medicaid nursing home enrollees sampled for this study had assets in amounts above the \$2,000 threshold. Statewide, it is estimated that individuals who applied for the program's nursing home benefits in FY 1991 owned more than \$79 million in assets, most of which was not initially counted when their eligibility was determined.

### **A Small Number of Applicants Do Not Disclose Their Property**

If a person owns property at the time of Medicaid application but does not qualify for an extended exemption, there is an incentive to "hide" the property from the Medicaid eligibility worker by failing to report it. In Virginia, this incentive is made stronger because the State forces all applicants with non-exempt property to sell the real estate after six months.

DMAS has developed a quality control program which indicates that only a small proportion of persons in nursing homes do not fully disclose their property when applying for benefits. However, the sample for this program is taken from the universe of all Medicaid recipients and thus might not adequately represent new applicants for nursing home benefits.

JLARC staff found that approximately eight percent of the persons who were approved for benefits failed to report property. The reasons that applicants did not report this property could not be determined. In some cases, the property may have been transferred prior to the date of Medicaid application. In other cases, ownership of the property may have been challenged in court.

***Recommendation.** The General Assembly may wish to consider requiring the Clerks of the Court to conduct property*

checks for all persons applying for Medicaid long-term care benefits. These property checks should cover the three-year period prior to the date that the application for benefits was submitted. To facilitate these checks, the Department of Social Services should require each local office to send to the Clerks of Court, on a monthly basis, the names of new Medicaid applicants.

### **\$14 Million in Assets Is Legally Protected Using Medicaid Loopholes**

Due to the complexity of Medicaid eligibility policy, there are a myriad of strategies that applicants can use to divest or shelter resources from the program. In conducting file reviews and interviewing eligibility workers, JLARC staff identified a number of approaches that were used by Medicaid applicants seeking nursing home benefits. In some cases, the applicants paid attorneys to negotiate the eligibility process for them. In other cases, applicants appeared knowledgeable enough to take advantage of certain provisions without legal counsel.

Based on a review of property records, it is estimated that applicants legally protected more than \$14 million in assets when applying for nursing home benefits in FY 1991. This is a conservative estimate of the value of assets because JLARC staff did not identify property in other localities or states which may have been owned by these applicants. Some of the techniques used include the following:

- transferring resources in small increments each month so as to minimize the total period of ineligibility;
- using irrevocable trusts to shelter assets from the Medicaid program;
- purchasing expensive term life insurance as a means of passing resources on to relatives;

- paying family members for the "care" they provided in the years before the applicant applied for Medicaid.

The following recommendations could help to tighten restrictions on asset transfers in Virginia.

**Recommendation.** *The Department of Medical Assistance Services should use the authority recently provided by the Health Care Financing Administration to adopt a State regulation permitting eligibility workers to count multiple transfers as a single transaction.*

**Recommendation.** *The General Assembly may wish to adopt legislation giving the Department of Medical Assistance Services the authority to count the resources used by Medicaid applicants to purchase term life insurance policies which have benefit to premium ratios that are lower than an established threshold. The time period in which these transfers can be regarded as inadequate compensation should be 30 months prior to the date that the person applies for Medicaid nursing home benefits. The State Bureau of Insurance should assist in the development of an appropriate benefit to cost ratio standard.*

### **Federal Law Permits States to Recover the Cost of Care**

Federal law provides states with two methods to help recover resources from recipients to defray the cost of nursing home care. First, states may place liens on the real property of institutionalized Medicaid beneficiaries for whom the state has determined that institutionalization is permanent. If a lien exists, the property holder must first satisfy the lien before the property can be sold or transferred.

Second, states can defray the cost of nursing home care by placing claims against recipients' property after their death. Under this option, the state files a claim against the

estate of a deceased Medicaid long-term care recipient for the cost of the benefits provided. As with the placement of liens, however, recovery cannot be made until the spouse or any surviving children under age 21 who are blind or disabled no longer need the home.

### **DMAS' Current Estate Recovery Policy Yields Little Savings**

Estate recovery in Virginia is not a proactive process in that DMAS does not, for the purpose of estate recovery, routinely track or collect data on recipients who own real property. DMAS officials indicated that they will consider recovering from the estates of deceased recipients only if they receive a report that a recipient's estate is in probate. This strategy has not, however, resulted in substantial recoveries. Since 1989, the agency has recovered approximately \$45,000.

According to DMAS officials, the agency does not have the resources required to initiate recoveries in a timely manner. By the time the agency has been notified of the recipient's death, many of the estates have already been probated. Because the State does not have an opportunity to place a claim against the estate prior to probate, it is unable to realize any of the proceeds of the estate.

### **Property Is Available to Recover Cost of Nursing Home Care**

JLARC's review of the property records of a random sample of 447 recipients who were discharged from a nursing home in 1990 shows that 16 percent of these recipients continued to own real property at the time they were terminated from the program. The average property value for these recipients was \$47,706. Statewide, recipients who were discharged in 1990 owned \$41.3 million worth of property. This is a

conservative estimate because JLARC staff were unable to identify all property owned by these recipients.

The value of property owned by Medicaid recipients at the time of discharge, in and of itself, is not indicative of the amount of money that could be recovered through estate recovery. The property value (less any mortgage owed) must be compared to the amount of benefits that have been paid on behalf of the recipient. The lesser of the two represents the amount of money that could be recouped.

JLARC staff analysis of both property values and benefits paid indicates that the State could recover as much as two-thirds of the total cost of nursing home care for recipients who were discharged in 1990. In total, it is estimated that approximately \$9.7 million could be recovered from these recipients if the State had a proactive recovery program. However, because some of this property would still be considered exempt according to federal law, only a portion of this amount is immediately available for recovery.

**Recommendation.** *In order to defray the cost of nursing home care, the General Assembly may wish to consider requiring the Department of Medical Assistance Services to implement a proactive estate recovery program.*

### **Lien Authority Would Enhance Recovery Potential**

It appears that lien authority could improve the State's ability to ensure that the proceeds of the sale of a home are applied to the recipient's care. The most obvious advantage of the use of lien authority is that it enhances the State's ability to preserve assets. By placing a lien on property at the time the recipient enters a nursing home, the State is ensured that the home will not be sold or transferred unless the State's interest is first satisfied.



Although states are prevented from foreclosing on a lien if there is a surviving spouse or dependent child in the home, the lien will effectively hold the State's interest in the property until the home is sold. At this time, the State's claim will automatically be considered along with other claimants.

Under current State law, DMAS is prevented from placing liens on nursing home residents receiving Medicaid assistance. Specifically, section 63.1-133.1 of the *Code of Virginia* states:

No lien or other interest in favor of the Commonwealth or any of its political subdivisions shall be claimed against, levied or attached to the real or personal property of any applicant for or recipient of public welfare assistance and services as a condition of eligibility therefor or to recover such aid following the death of such applicant or recipient.

By changing this law to permit recoveries from Medicaid recipients, the State's chances of preventing property from being sold or otherwise disposed of before its claim is satisfied could be greatly improved.

**Recommendation.** *To enhance Virginia's ability to recover benefits paid on behalf of institutionalized Medicaid recipients, the General Assembly may wish to consider revising Section 63.1-133.1 of the Code of Virginia to allow liens to be attached to the real property of Medicaid recipients of nursing home benefits.*

### **Programmatic Changes Are Needed for Estate Recovery**

In order to implement a more proactive recovery program in Virginia, certain programmatic changes would be required that would allow DMAS to better identify, track, and recover assets. The most significant of these changes would be in the recovery process itself. In order to implement these changes, it is likely that DMAS will require additional resources. Any decision about the structure of a recovery program should incorporate the findings of a detailed analysis of resource requirements.

**Recommendation.** *The General Assembly may wish to direct the Department of Medical Assistance Services to conduct an analysis of the amount of resources that would be required to implement a proactive estate recovery program.*

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# **I. Introduction**

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Medicaid is a public health care program jointly financed by the federal government and the states to fund a variety of basic health and medical services for mostly low-income residents. The State agency responsible for the implementation of the Medicaid program in Virginia is the Department of Medical Assistance Services. This agency makes payments for a specified range of health and long-term care services when they are delivered by approved vendors on behalf of persons who meet the program's eligibility requirements.

One of the major benefits provided by Medicaid is coverage for nursing home care. In Virginia, an individual without coverage for these services faces annual nursing home costs which can range from \$26,000 to \$40,000 depending on the geographic location of the facility. However, if that person is receiving Medicaid, providers of nursing home care will accept a lower per diem rate as payment in full for its services.

Since Medicaid was first implemented in Virginia in 1969, it has become the principal method through which most of the State's nursing home costs are paid. Although only about 14 percent of the State's elderly population live on incomes below the poverty level, almost 60 percent of the total nursing home patient days in Virginia are paid for by Medicaid.

These figures have raised concerns that a substantial portion of program funds are being spent on middle-and upper-income residents who have successfully sheltered their assets from the program as a means of having the public pay for their nursing home care. As a result of these concerns, the 1991 General Assembly passed Senate Joint Resolution 91 directing the Joint Legislative Audit and Review Commission (JLARC) to support the Joint Commission on Health Care in reviewing Medicaid recipients' use of asset transfers to qualify for the program.

This report presents the results from JLARC's review of Medicaid asset transfers. Included in this review is an analysis of the extent to which people transfer assets to establish eligibility and a description of some of the strategies used to conduct the transfers. In addition, this report also discusses results from an assessment of the potential benefits of establishing a program to recover Medicaid nursing home costs from the estates of recipients.

## **NURSING HOME CARE IN VIRGINIA: WHO PAYS?**

One of the major types of basic health services available to elderly and disabled citizens in Virginia is nursing home care. Presently, there are more than 240 nursing homes across the State. In FY 1990, these homes provided more than 10 million days of care.

While persons of almost any age can be admitted to a nursing home, the primary mission of these facilities is to provide residential services and basic health care to elderly persons with diminished mental and physical capacities. The types of care provided in these homes can range from basic services such as personal hygiene and toileting, to more complex invasive therapies such as tube feedings and catheter irrigations.

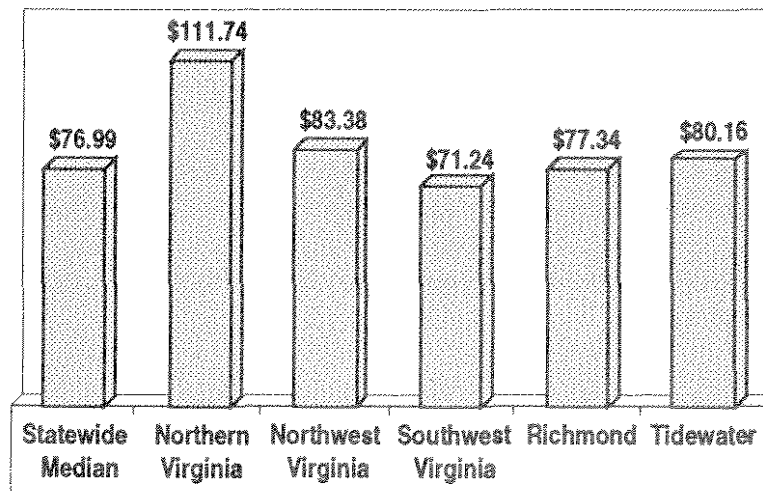
The daily rate which providers of these services charge their residents varies substantially according to the geographic location of the facilities. Data collected by the Virginia Health Services Cost Review Council indicate that the typical nursing home charged its residents \$76.99 in 1991 (Figure 1). The charge rate was substantially higher for facilities in Northern Virginia (\$111.74), Northwest Virginia (\$83.38), and the Tidewater Region (\$80.16). With these daily rates, the annual cost of nursing home care for a person who is uninsured and not receiving publicly-financed health care could range from about \$26,000 to \$40,000.

### Sources of Funding for Nursing Home Care in Virginia

Providers of nursing home care in Virginia typically accept payments from the following sources: the income and resources of its residents; the federally-funded Medicare Program; the Medicaid Program; and private insurance companies which offer long-term care benefits.

Figure 1

#### **Daily Patient Charge Rates for Nursing Homes in Virginia According to Geographic Area**



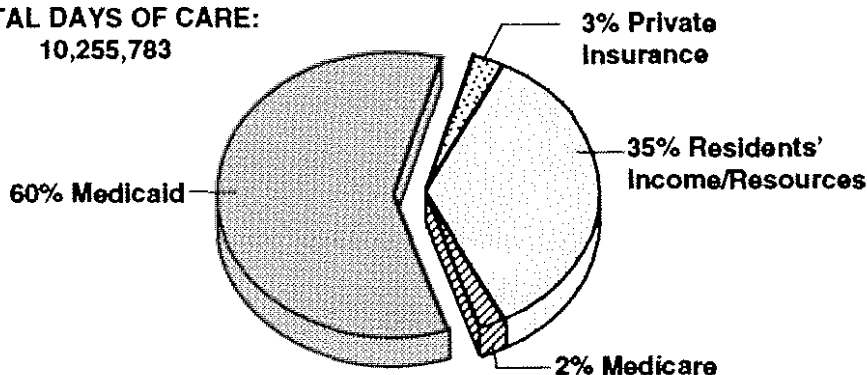
Source: Nursing home rates were reported in the 1992 Annual Report for the Virginia Health Services Cost Review Council.

Figure 2 clearly illustrates that the primary source of payment for nursing home care in the State is the Medicaid program. In FY 1990, Medicaid paid for almost 60 percent of the 10 million days of care provided by nursing homes. The second largest payment source was the private income and resources of uninsured nursing home residents (35 percent). Medicare (2 percent) and private insurance companies (3 percent) paid for considerably smaller amounts of the State's nursing home services.

Figure 2

### Total Nursing Home Days of Care Provided in Virginia, by Payment Source, 1990

TOTAL DAYS OF CARE:  
10,255,783



Note: Data from 25 hospital-based nursing homes were not available.

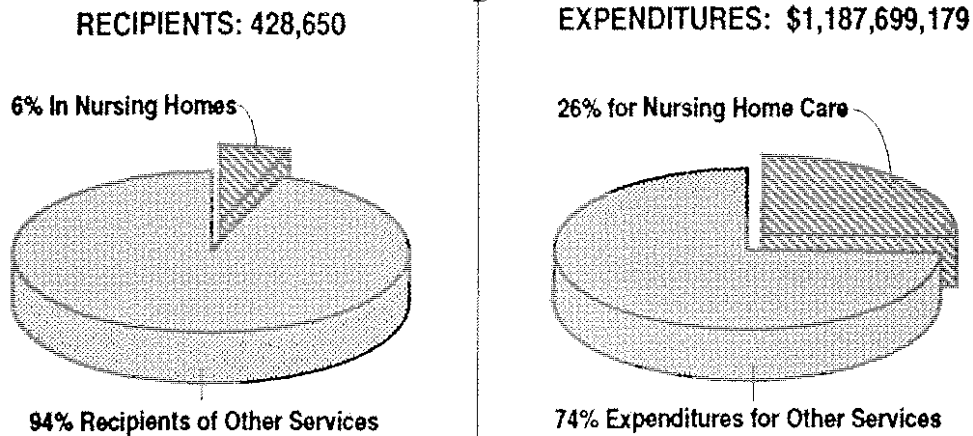
Source: Nursing home rates were reported in the 1992 Annual Report for the Virginia Health Services Cost Review Council.

**Impact on Medicaid Budget.** In devising a reimbursement system for nursing home providers, the Department of Medical Assistance Services (DMAS) has been able to pay a lower rate for Medicaid recipients. In addition, the number of recipients for which DMAS made payments in FY 1991 was only six percent of the total number of persons on Medicaid. Despite this, DMAS currently spends approximately \$312 million on these services (Figure 3). This is just over one quarter of the total medical care expenditures for the program.

One reason for this large Medicaid expenditure for such a relatively small segment of the program's recipients is the length of time individuals stay in a nursing home while receiving Medicaid. Figure 4 illustrates the varying lengths of stay for Medicaid recipients who were terminated from the program in 1990. The typical Medicaid recipient in an institution will receive payments for a nursing home stay of 15 months. About one-quarter of these persons received Medicaid-supported nursing home care for up to four months. However, at the other extreme, 40 percent of the recipients terminated from Medicaid in 1990 had been in a nursing home for more than two years.

Figure 3

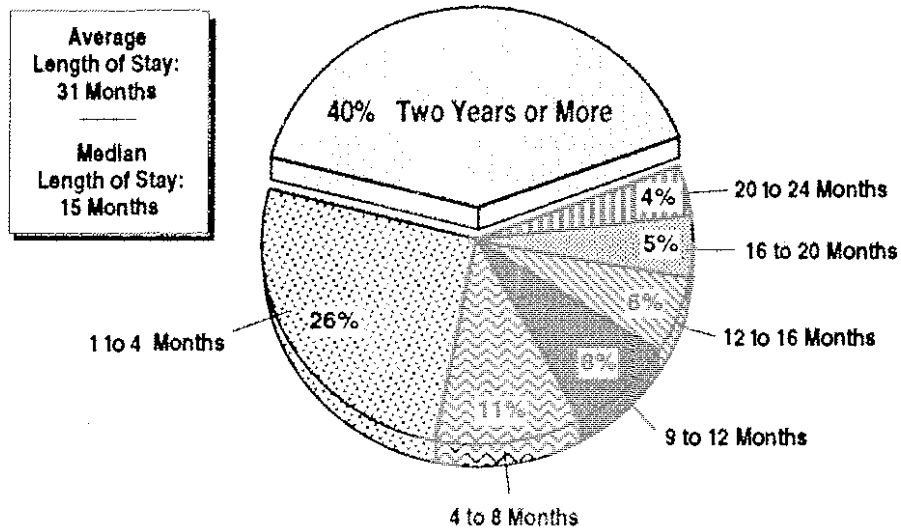
### Number of Medicaid Recipients and Expenditures by Type of Service Provided



Source: JLARC staff analysis of data from the Department of Medical Assistance Services' recipient file and internal expenditure report.

Figure 4

### Length of Stay in a Nursing Home While on Medicaid for Persons Who Were Discharged in 1990



Note: Calculations for length of stay in nursing homes include persons with multiple admissions.

Source: JLARC staff analysis of data from Department of Medical Assistance Services automated recipient files.

Even with the lower reimbursement rate that providers will accept from Medicaid, the cost associated with providing 15 months of nursing home care can be substantial. For example, in 1990 the median reimbursement rate per diem paid by Medicaid was \$54.24. If a person were to establish eligibility, had no income or resources to contribute to his care, and stayed in the nursing home for 15 months, Medicaid would pay the provider more than \$25,000.

## STUDY MANDATE

Senate Joint Resolution 91 (Appendix A) was passed during the 1991 session of the General Assembly. This mandate requires JLARC to work with the Joint Commission on Health Care (JCHC) to determine the extent to which Medicaid applicants use asset transfers to qualify for nursing home benefits.

The review authorized by this mandate is one of four JLARC studies focusing on the Medicaid program. Although these studies deal with different aspects of Medicaid funding, the impetus for each of the evaluations is legislative concern about the rising costs of the program.

With asset transfers, the concern is that many people who can afford to pay for all or a large portion of their nursing home costs are sheltering resources and using Medicaid to subsidize their care. While these strategies are legal, many feel they undermine the basic intent of Medicaid, which is to increase access to health care for persons with low income. At the same time, the extension of program benefits to people who have the means to pay for their care places additional fiscal pressure on the State's budget already strained by the rapid growth of Medicaid.

Despite the concern about the impact of Medicaid asset transfers, only anecdotal information exists about the actual magnitude and nature of the problem in Virginia. Therefore, in order to gain access to more systematic and comprehensive data on this issue, the JLARC review of asset transfers was requested.

## STUDY APPROACH

The JLARC review of Medicaid asset transfers was broadly designed to address two major concerns: (1) that a large proportion of Medicaid applicants are transferring assets in order to shift the costs of their nursing home care to the Medicaid Program; and (2) that the State is waiving the opportunity to recover a large portion of Medicaid expenditures for nursing home care by not implementing a formal estate recovery program. Based on these two concerns the following research questions were developed:

- What proportion of persons who apply for and receive Medicaid nursing home benefits have resources that exceed the allowable limits?

- How do these individuals establish eligibility?
- How many Medicaid applicants transfer assets either before or after they begin receiving Medicaid nursing home benefits?
- What is the total amount of the resources that were transferred by persons who applied for and received Medicaid nursing home benefits in FY 1991?
- What were some of the strategies used by these Medicaid recipients to transfer assets?
- What options are available to the State to reduce the impact of asset transfers in the Medicaid program?
- At the time that they are terminated from the Medicaid program, what proportion of nursing home recipients have real estate that could be used to defray the cost of the care?
- Given the value of this real estate, would it be cost-effective to establish an estate recovery program in Virginia?

To address these questions, two major strategies were used. First JLARC staff examined State income tax data to evaluate the pre-Medicaid income trends for persons who received nursing home benefits from the program for the first time during 1990.

Second, the study team conducted interviews with local Medicaid eligibility workers, reviewed recipient applications, and examined local property records. These activities provided the additional information needed to assess the magnitude of asset transfers involving nursing home enrollees and evaluate the potential benefits of an estate recovery program. The next section in this report provides a general discussion of these research activities.

### **Examining Pre-Medicaid Income Trends**

Any attempt to assess the possibility that Medicaid recipients are transferring assets to establish eligibility must include an evaluation of income-producing assets (e.g. stocks or certificates of deposit) that recipients might possess prior to application. The best source of this information is the recipient's federal tax returns. This information, which is maintained by the Internal Revenue Service (IRS), contains data on the components of each tax filer's income. However, federal confidentiality laws reserve the use of this data to the IRS. As an alternative, the JLARC study team used data on each recipient's federal adjusted gross income (FAGI) which is maintained by the Virginia Department of Taxation (DOT) on residents who pay State taxes.

Computer Match of Tax Data. To retrieve FAGI data on Medicaid recipients, the study team worked with DOT's management information analysts. These staff merged



FAGI data onto a file containing information on all recipients of Medicaid long-term care services who received program benefits in FY 1991.

The Medicaid database used to conduct the tax match was constructed using DMAS' automated eligibility and claims files. Once the file was created, a tape was sent to DOT which merged recipients' FAGI data, tax filing status, and their marital status for each of the five years from 1986 to 1990.

*Identifying New Enrollees.* When conducting the examination of pre-Medicaid income, it was important to include only those persons who received Medicaid-supported nursing home care for the first time in FY 1991. This eliminates all persons who had a previous nursing home stay for which they may have divested financial assets prior to the period under study.

To accomplish this, the JLARC study team used the Medicaid recipient and claims files. The recipient file identifies the starting and ending dates for each occurrence of a period of Medicaid eligibility, as well as the dates that recipients were admitted to and discharged from a nursing home. The claims file indicates the amount of the Medicaid payment that was made for each recipient according to the type of service received (for example, nursing home services, inpatient hospital services, or home health.)

To be included in the study group, the recipients had to meet two conditions: (1) a Medicaid claim for nursing home care must have been paid on their behalf at any time during FY 1991; and (2) their eligibility records had to indicate that FY 1991 was the first time that they were enrolled in Medicaid.

Once this group was identified, JLARC staff were then able to analyze trends in pre-Medicaid income levels. In particular, staff were able to determine if there was a drop in the number of Medicaid new nursing home enrollees who filed taxes prior to receiving assistance. If other more obvious reasons for any substantial declines in the number of persons paying taxes could be eliminated, this might be an indication of the number of persons that were reducing their resources to apply for Medicaid.

### **Medicaid Asset Transfers**

Financial resources are only one, and perhaps the smallest, component of the typical elderly Medicaid recipient's total assets. To get a more comprehensive picture of this group's resource level, information must be gathered on their real estate holdings. National studies estimate that real estate accounts for 70 percent of the elderly's total assets.

State tax data does not provide the information needed to evaluate whether the elderly are giving away property to qualify for Medicaid. Nor is there a centralized database which documents how Medicaid recipients established eligibility for nursing

home benefits given their ownership of property or other resources that may have been identified when they applied for assistance.

To more closely examine the eligibility process and identify the real estate holdings of Medicaid new nursing home enrollees, JLARC staff randomly selected 14 local eligibility offices to visit, conducted structured interviews with eligibility workers at these offices, analyzed Medicaid documents for a sample of applicants, and reviewed the applicants' property records.

*Sample Selection.* In selecting the offices to include in this aspect of the study, JLARC staff stratified Virginia's 124 local social service offices according to geographic location and the size of their Medicaid caseload. From this universe, 10 offices were randomly selected. In addition, four additional offices were selected based on location and caseload size. Appendix B provides a list of each office included in the study and a discussion of the sampling strategy.

*Structured Interviews with Eligibility Workers.* At each of the 14 offices, the study team interviewed the workers responsible for conducting Medicaid intake for long-term care and performing the routine (usually annual) redeterminations of recipient eligibility. These interviews covered a number of topics. Workers were asked to describe the income and resource information that is collected on each applicant and discuss their use of the Income Evaluation Verification System.

Also, the interviews included a number of questions on Medicaid asset transfers. Workers were asked to discuss the procedures they use to check for the possibility that transfers had been inappropriately made. In addition, they were asked about the accuracy of the perception that attorneys are becoming increasingly involved in the Medicaid application process for persons seeking nursing home care.

*Selecting a Sample of Medicaid Applications for Review.* Two approaches can be taken when sampling Medicaid recipients for the purpose of identifying the magnitude and nature of applicant asset transfers. One approach is to randomly select only those cases who were initially denied Medicaid nursing home benefits but were later approved. This would better isolate those cases for which some type of asset transfer probably occurred. However, this approach ignores those individuals who transferred assets prior to first being admitted to the program, nor can it be used to provide an unbiased estimate of the magnitude of the problem.

A second approach, and the one used for this study, is to randomly select a sample from the universe of all new Medicaid nursing home admissions in a given year. Such a strategy better allows for identification of the proportion of applicants who transfer assets to get Medicaid nursing home benefits by eliminating the bias inherent in sampling from only persons who re-applied for Medicaid after an earlier denial. These individuals are included with the sampling approach used by JLARC but not to the exclusion of other applicants.

In each office visited by the study team, a sample of applications was reviewed for persons who received Medicaid support for a nursing home stay which began in FY 1991. The total number of cases sampled in all 14 offices was 510. From these applications, information was collected on the applicant's reported income and resources and whether the eligibility workers could identify any asset transfers. If transfers were either reported or found by the eligibility workers, the study team documented how this affected the eligibility status of the applicant.

*Review of Local Property Records.* A home and surrounding land are typically the largest assets of most elderly persons in this country. To determine if real estate transfers were being made and not reported, or whether applicants were underreporting these assets, the study team checked the property records for each of the 510 persons in the sample. The time period for which property was examined was three years prior to the date of the recipient's nursing home admission. In most localities, these records were maintained in "land books" in the Clerk of the Court or the Commissioner of Revenue's offices.

### **Evaluating the Potential Benefits of an Estate Recovery Program**

The key issue regarding estate recovery is whether recipients of nursing home benefits have sufficient property when they are no longer eligible for Medicaid to justify the establishment of an estate recovery program.

To examine this question, JLARC staff first interviewed local eligibility workers concerning the procedures they use to identify recipient property holdings, track the status of that property while the person receives care, and when appropriate, establish claims on the property of persons who die in care. Next, the study team checked local property records for a sample of recipients whose eligibility ended 1990 to determine how many of these recipients owned real estate. Finally, for each recipient who owned property, JLARC staff identified the total amount of nursing home benefits that were paid on these individuals' behalf to determine the amount that could potentially be recovered.

*Interviews with Eligibility Workers.* In Virginia, when unmarried Medicaid recipients with no dependents enter a nursing home, their principal residence is not considered a countable resource for six months. After the six-month period, a reasonable effort must be made to sell the property or the recipient's eligibility for Medicaid is terminated. If the recipient dies in a nursing home, in most cases the State can place a claim on the property if it goes to probate.

During structured interviews with eligibility workers, JLARC staff asked questions about the procedures used to track the status of property that must be sold after this six-month period. In addition, these staff were asked what if any role they played in placing claims on the property of recipients who die in care.

*Review of Property Records for Sample of Recipients.* Because it is possible for recipients of Medicaid nursing home benefits to die in a nursing home before any property that they may own is sold, JLARC staff examined the property records for a sample of 452 such Medicaid recipients in the 14 localities visited during the study.

In selecting the sample, JLARC staff first identified the universe of Medicaid recipients who were no longer in a nursing home or eligible for the Medicaid program in 1990. Next, the study team reviewed the Medicaid files of these individuals to check for the existence of property. Finally, the property records were examined for each person in the sample for the three-year period before they were terminated from the program.

As noted, these records were maintained in "Land Books" located in each city and county. When property was identified, JLARC staff recorded the assessed value of the real estate.

*Identification of Nursing Home Payments.* The total amount of Medicaid nursing home benefits that are paid for each recipient, dating back to 1984, is maintained in claims files by DMAS. JLARC staff merged this information with a database containing the property holdings of Medicaid nursing home recipients who were terminated in 1990. This enabled the study team to calculate the amount of benefits paid out that could be recovered if the State had lien authority and established a formal estate recovery program.

## REPORT ORGANIZATION

The two remaining chapters in this report provide an analysis of Medicaid asset transfers and estate recovery issues. Chapter II presents an analysis of the resource levels of Medicaid nursing home enrollees. In addition, the incidence of Medicaid asset transfers in Virginia is presented and some of the approaches that are used by various program recipients are described. Chapter III discusses the potential benefits of an estate recovery program for the State.

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## **II. Medicaid Asset Transfers in Virginia**

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Although the majority of Medicaid recipients of nursing home benefits are persons with low incomes and very few assets, federal laws for the program make it possible for applicants to gain access to these benefits while retaining substantial amounts of their resources. As would be expected under these circumstances, a significant number of people do qualify for Medicaid without having to use a large portion of their assets.

Due in part to these resource exemptions, 37 percent of the new Medicaid nursing home enrollees sampled for this study had assets in amounts that were higher than the limits imposed by the program. Statewide, it is estimated that individuals who applied for the program's nursing home benefits in FY 1991 owned more than \$79 million in assets such as their homes and real property, most of which was not initially counted when their eligibility was determined.

Under federal law, Medicaid applicants can legally reduce their total resource levels prior to seeking admission to the program. Among the recipients sampled for this study, 27 percent transferred assets prior to, or shortly after, establishing eligibility for Medicaid nursing home benefits. Based on this number, it is estimated that more than \$43 million in resources were transferred by persons who entered the Medicaid program in FY 1991.

Many of these transactions were made by applicants to generate cash which was used to pay medical bills and a portion of their nursing home expense. However, a smaller number of applicants used loopholes in the Medicaid eligibility laws to shift the costs of their care to the taxpayer while preserving more than \$14 million in assets for their heirs.

In the future if federal and State laws are not adopted to discourage these practices, the number of persons who transfer assets with the intent of qualifying for Medicaid nursing home benefits could grow significantly, especially with Virginia's growing elderly population.

### **THE ISSUE OF ASSET TRANSFER**

Because of the cost of nursing home care and the general absence of other third party payors, there is a growing concern that many middle- and upper-income residents are transferring their assets to qualify for Medicaid. According to some analysts, the fact that the proportion of people on Medicaid in nursing homes exceeds the percentage of elderly who are poor indicates that the program is being used to subsidize the nursing home costs for persons who could afford to pay for either a portion or all of their care.

There are other analysts who disagree with this view. They acknowledge that a number of middle-income people do rely on Medicaid for nursing home benefits. However, they argue that this occurs not through asset shifting but only after these individuals have depleted their resources on expensive nursing home services and have no other means to pay for their care. The next section of this chapter outlines the steps taken by the federal government to limit the practice of asset transfers.

### **Congress Has Been Slow to Place Restrictions on Asset Transfers**

Despite the significant impact that Medicaid asset transfers can have on federal health care expenditures, the Congress has been slow to place restrictions on the practice. In the first 16 years after Medicaid was adopted, there were no federal laws or regulations preventing recipients from giving away assets to qualify for nursing home benefits. Since that time, Congress has passed three different laws designed to tighten restrictions on this practice.

***Boren-Long Amendments.*** In the 1980 Omnibus Budget Reconciliation Act, Congress took steps to address the problem of asset transfers by passing the Boren-Long Amendments. These amendments gave states the authority to deny Supplemental Security Insurance (SSI) benefits to persons who transferred assets for less than fair market value. Because states based some of Medicaid's eligibility guidelines on SSI regulations, this option could be used to deny services for as long as 24 months for persons who transferred assets.

The problem with the Boren-Long amendment was that it only restricted transfers of non-exempt assets. However, in many states, a Medicaid applicant's home was initially considered an exempt asset. Thus, it was possible for Medicaid recipients in nursing homes to transfer property to family members while it was still considered exempt by the state. This effectively protected large amounts of assets from the transfer restrictions.

***Tax Equity and Fiscal Responsibility Act (TEFRA).*** Congress moved to close the transfer of assets loophole in 1982 by passing TEFRA. While TEFRA dealt with a number of issues surrounding Medicaid, there were two key provisions which pertained to asset transfers. First, states were allowed to deny Medicaid assistance to persons who transferred assets that may have been excluded — such as the home — when the application for benefits was initially made.

Second, restrictions were placed on transfers made within two years of Medicaid application. When such transfers were made, States could deny Medicaid eligibility. The actual length of the period of ineligibility was determined by the value of the assets for which the recipient was not compensated.

While the intent of Congress in establishing these new laws was clear, states were not required to impose these restrictions. As a result, there was uneven implementation of these laws.

Medicare Catastrophic Coverage Act (MCCA). In 1988, Congress addressed this problem by mandating that all states with Medicaid programs adopt asset transfer restrictions as official policy. Next, it extended the period during which asset transfer could not be made to 30 months prior to eligibility. While these changes strengthened asset transfer restrictions in many states, DMAS and DSS officials point out that MCCA actually weakened Virginia's ability to stop this practice. Prior to MCCA, local eligibility workers could use provisions under TEFRA to establish periods of ineligibility for persons who illegally transferred assets which exceeded 30 months.

Soon after MCCA was passed, the Congress did close a loophole in the law pertaining to property transfers by the spouse of the Medicaid recipient. In some instances, individuals who were institutionalized would give their spouse sole ownership of the house. Once this was done, the spouse could then transfer the property to a relative or friend. This was often done to evade any state claims against the property at a later date.

MCCA contained no provisions to prevent this practice. As a result, Congress used the 1989 Omnibus Budget Reconciliation Act to allow states to cancel the benefits of Medicaid recipients if the spouse gives property away while the person is still receiving care.

## **VIRGINIA'S MEDICAID RESOURCE RESTRICTIONS**

In order to assess the strength of the existing federal asset transfer restrictions, it is important to understand what are considered resources by Medicaid and how they are treated when an application for nursing home benefits is made.

In general, the term resources for the Medicaid program refers to all liquid assets — such as stocks, bonds, cash on hand, or savings — as well as non-liquid assets such as real estate and personal property. Applicants who satisfy the program's income requirements must meet Virginia's resource standard before eligibility is granted. Presently, the State's resource standard for the program is \$2,000 for a single person and \$3,000 for married persons. If local eligibility workers determine that an applicant's resources exceed these limits, that individual is ruled ineligible for nursing home benefits.

### **Virginia Has to Initially Exempt Property of Applicants**

When determining whether an applicant meets Medicaid resource standards, the State must address two basic questions: (1) Are the applicant's assets countable or are they explicitly exempt under law? (2) Are those assets which are countable actually accessible to the applicant?

Non-Countable Assets. In calculating an applicant's resource level, states must classify certain resources as countable and others as non-countable. For example, federal

law requires that the primary residence of persons seeking nursing home benefits be excluded from countable resources when the house is occupied by a spouse, dependent child under 21, or a disabled son or daughter of any age. In most states, eligibility workers must also exempt the property as long as the nursing home residents express an intent to return home.

Virginia's policy concerning the intent to return home is more restrictive than most other states. Specifically, all Medicaid nursing home recipients who do not actually return home in six months must make a reasonable effort to sell their property. If they refuse, the house is no longer considered an exempt resource and they lose eligibility.

Virginia can use this more restrictive criteria for property exemptions because of its status as one of 14 209(B) states in the country. The term 209(B) is used to refer to one provision in the Social Security Act which granted all states the option to use more restrictive guidelines when determining the eligibility of SSI recipients. States could use this provision only if they had such criteria in place prior to passage of this portion of the Social Security Act. Virginia has used its 209(B) status to establish the shorter time period for property exemptions and apply more stringent limitations on the amount of contiguous property a recipient can own.

*Inaccessible Assets.* Even if a person has assets that are not by definition exempt, states must determine if such resources are accessible. Inaccessible assets are those which are normally countable but which may be held under certain circumstances, requiring the State to rule explicitly that they are not available to the applicant.

This can include any resource which the applicant previously owned but has given away through irrevocable, non-discretionary trusts. It may also include any property that the applicants only have a life interest in — the right to use the property while they are alive. In this case, because the applicant cannot sell the property or force it to be sold, the value of the life interest is considered inaccessible. However, if the owner of the property purchases the life interests rights of the Medicaid applicant, then the proceeds from the purchase are counted by the State as a resource.

Table 1 summarizes key aspects of the State's policy regarding the treatment of resources. Some of the assets which are not counted at the time an application for nursing home benefits is submitted include the following:

- **Personal Effects.** All of an individual's personal effects such as jewelry and clothing are exempt regardless of value.
- **Household Furnishings.** All of the furniture and equipment that is a part of the applicant's home or former residence is exempt.
- **Life Insurance.** Any life insurance that does not have a cash value is an exempt resource.
- **Irrevocable Trusts.** Any (non-Medicaid qualifying) trust through which the applicant has permanently given up legal rights to his resources is exempt.



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Table 1

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**Virginia's Policy Regarding the Treatment of  
Resources for Purposes of Determining  
Eligibility for Medicaid**

<u>Resource</u>	<u>State Policy</u>	<u>Exceptions</u>
Primary Residence	Not counted for first 6 months in nursing home	Exemption is extended when house is occupied by -spouse -certain children -certain relatives
Life Interest In Property	Not counted	None
Undivided Property	Counted	Not counted if interest can not be sold
Household Furnishings	Not counted	Counted if items not used in home
Personal Effects	Not Counted	None
Automobile	Not counted	Only one vehicle is exempt
Burial Funds	Not counted up to \$2,500	No limit if held in an irrevocable trust
Life Insurance With No Cash Value	Not counted	None
Joint Accounts	One-half of the assets in the account are attributed to applicant	Not counted if evidence demonstrates applicant did not own resources in the account

Source: JLARC staff analysis of the Virginia Medicaid Policy Manual.

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The powers of DMAS for treating certain resources as available to the applicant are expanded by legislation which allows the agency to count property that is jointly owned. In these circumstances, local eligibility workers are required to calculate how much of the jointly owned property is available by subtracting the legal cost of a partition suit from the applicant's share of the asset. If the remaining amount is above the Medicaid resource limit, the applicant must agree to force the sale of the property or be denied care.

## Medicaid Resource Restrictions for Married Persons Are Generous

In 1988, when MCCA was passed, some of the key provisions of that legislation were designed to address the issue of Medicaid "spousal impoverishment." Prior to the passage of MCCA, states used very strict guidelines for determining how much of the resources jointly held by married couples were available to pay for nursing home care. In some cases, states could consider all of the couple's income and resources to be available for this purpose. In doing so, these states would only allow a small amount of money to be set aside for the support of the spouse who remained in the community.

To correct this problem, MCCA created financial protections for the spouse remaining in the community by establishing a "Community Spouse Resource Allowance (CSRA)." Under this provision, a spouse must be allowed to keep a minimum of \$13,740 to a maximum of \$68,700 of the couple's countable resources. The actual amount protected within this range is left to the discretion of the states. In Virginia, the minimum amount is applied as the State standard.

It is the responsibility of local eligibility workers to determine the CSRA for the spouse who will remain in the community. This is typically done through a resource assessment process before an official application is submitted for nursing home benefits.

Establishing the CSRA first involves a determination of the couple's total countable income. Second, the couple's spousal share is determined by dividing their total countable assets by two. Next, a spousal protected amount is determined by subtracting from the couple's total assets the greater of the spousal share or the State's resource standard. The following provides a hypothetical case involving a basic application of the CSRA.

*On January 1, 1992, John Doe is admitted to a nursing home because he is disabled and his wife can no longer care for him. At the time of his admission, their assets include a \$110,000 home and \$60,000 in savings accounts and several certificates of deposit. The house is an exempt resource because John's wife will still live in the community. This means that the couple's spousal share is \$30,000 (total non-property assets divided by two.) Three months after being admitted to a nursing home, John Doe applies for Medicaid. At this time, their resources have been reduced to \$32,000 due to expenditures on medical care and three months of nursing home care. The eligibility worker compares the original spousal share (\$30,000) to the State's minimum resource level (\$13,740). Because the spousal share is greater, this figure is subtracted from the couple's total available assets of \$32,000, leaving \$2,000 in resources. This allows Mr. Doe to establish Medicaid eligibility while leaving Ms. Doe with \$30,000 of protected income.*

## **Options Available to Medicaid Applicants with Excess Resources**

Medicaid applicants who fail to meet the resource standard after countable resources have been identified are immediately determined to be ineligible. If the applicant attempts to give away the excess resources in an effort to qualify for nursing home care, the previously discussed federal restrictions are applied and the local eligibility worker can assess a period of ineligibility based on the uncompensated value of the assets that were given away.

*Other Paths to Medicaid Eligibility.* There are several routes to Medicaid nursing home benefits that do not involve illegal transfers which can be pursued by these individuals. One option would be to impoverish themselves by using the excess resources to pay for their nursing home care or other medical expenses. Once their resources were reduced to the Medicaid allowable limit, they could re-apply for Medicaid coverage of their long-term care costs.

A second option would be to anticipate the need for nursing home care far enough in advance so that resources could be transferred without penalty. As discussed earlier, federal law permits asset transfers of any amount when they occur 30 months prior to the date that the person applies for Medicaid.

A third option, for those who did not foresee the need for nursing home care far enough in advance, would be to look for "loopholes" in Medicaid eligibility policies that would permit the transfer of assets within the 30-month time period with little or no penalty.

Many experts contend that applicants are able to circumvent recently established federal asset transfer rules and effectively shelter resources from the reach of the Medicaid program. A particular concern of some is the growth in Medicaid estate planning. With a competent attorney, analysts point out that middle- and upper-income individuals can legally take advantage of Medicaid's complex eligibility rules and gain access to the program's nursing home benefits at little or no personal cost.

The next section of this chapter examines the resource levels of new Medicaid nursing home enrollees and evaluates, to the extent possible, the number of Medicaid applicants who transfer or shelter assets in order to gain access to the program's nursing home benefits.

## **RESOURCE LEVELS OF VIRGINIA'S MEDICAID RECIPIENTS**

One objective of this study was to assess the resource levels of persons who apply for and receive Medicaid nursing home benefits. The components of an individual's resources can include all liquid assets such as stocks, bonds, certificates of deposit, as well as non-liquid assets in the form of real estate holdings. Identifying evidence that these

assets exist can be a first step in determining whether a significant number of persons have resources which they divest in order to establish eligibility for Medicaid.

The findings from this analysis are mixed. First, four years prior to applying for Medicaid nursing home benefits, the majority of recipients did not have enough income from liquid resources or wages to place them above the tax filing threshold in Virginia. However, at the time that application for nursing home benefits was made by a sample of these individuals, more than one-third owned assets (mostly property) which often had value that substantially exceeded the resource limits for the program.

### **Most Nursing Home Enrollees Had No Taxable Income**

Measures of the amount of liquid assets held by persons who receive nursing home benefits are not readily available. As a proxy for this, JLARC staff examined the federal adjusted gross income (FAGI) as reported on the State tax returns by persons required to file Virginia income taxes.

The components of FAGI include taxable interest income, dividend income, capital gains, Individual Retirement Account distributions, and all business income. These details are not, however, maintained in the State's automated tax files. As a result, when analyzing this data, JLARC staff focused on the number of Medicaid new nursing home enrollees who filed taxes and the amount of income reported.

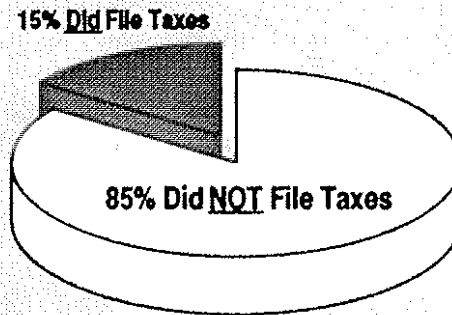
Several factors determined whether elderly citizens were required to file State taxes in 1986. Unmarried persons over 65 were required to file State taxes if their Virginia adjusted gross income (VAGI) exceeded \$2,900. Married couples had to file if their income exceeded \$4,500. In calculating VAGI, the elderly do receive an additional \$400 deduction. Also, any interest from obligations to the United States (for example, treasury notes) which are not taxed at the State level, are deducted from federal income. While these adjustments do reduce the number of elderly residents reporting income, the impact is probably minimal and not likely to affect the filing status of persons with substantial amounts of investment resources.

*Medicaid Enrollees With Pre-Program Taxable Income.* The results from matching the Medicaid file of new nursing home enrollees to the State's tax file for 1986 indicate that 85 percent of these 7,941 recipients did not file State taxes (Figure 5). For at least two reasons, this finding casts doubt on the notion that large numbers of beneficiaries of nursing home care are divesting liquid assets to gain access to the program.

First it is likely that elderly citizens who owned significant financial assets in 1986 had income from other sources (such as retirement benefits or Social Security) at levels that were above the low tax filing threshold in Virginia. This would mean that most of the elderly who were not required to file taxes were low-income residents with no pensions, limited Social Security benefits, and insignificant amounts of unearned income.

Figure 5

### Percent of Medicaid Nursing Home Enrollees Who Filed Taxes in 1986



Source: JLARC staff analysis of tax data from the Department of Taxation.

Second, because this tax filing rate was observed in 1986 — four years prior to the earliest nursing home admission date — it is not likely that many elderly residents had begun to shelter resources to establish eligibility for Medicaid. Typically, people cannot anticipate the need for nursing home care three or four years in advance. Thus it seems that there would be no incentive to start giving away assets.

This finding does not mean that the elderly do not engage in asset shifting or estate planning for the purpose of establishing Medicaid eligibility. As will be discussed later in this chapter, a review of recipient eligibility files did reveal a number of instances of asset shifting by applicants for Medicaid nursing home benefits. However, this particular finding simply raises questions about how widespread this practice is among new Medicaid enrollees in Virginia.

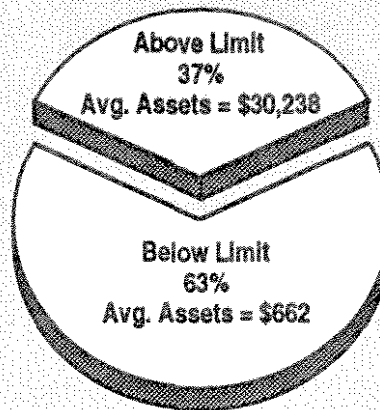
### A Number of Recipients Have Significant Resources

As noted earlier, most national studies point to home equity as the largest resource of the elderly. Because of this and the fact the property can be temporarily treated as an exempt asset, JLARC staff examined recipients' real estate along with any other assets identified by local eligibility workers when application to the program was made. When determining total assets, property that was identified by JLARC staff but not reported to the eligibility workers was included in the calculations.

Figure 6 indicates that when exempt property is counted, 37 percent of the 510 applicants sampled for this study had resource levels that exceeded program limits. Using data on the total amount of resources for this group, JLARC staff determined that the average amount of resources owned by Medicaid nursing home enrollees with assets over \$2,000 (the Medicaid resource limit) is \$30,238.

Figure 6

### Resource Levels for Sample of Medicaid Nursing Home Enrollees, FY 1991



TOTAL STATEWIDE PROJECTED RESOURCES: \$79,827,867

Notes: The sampling error for the estimate of the proportion of applicants with resources above the Medicaid limit is 4% at a 95% level of confidence. The 95% confidence level for total resources for this group has an upper bound of \$100,319,635 and a lower bound of \$61,650,582. This means that there is a 95% probability that the actual population mean is within the interval.

Source: JLARC staff analysis of recipient eligibility files in 14 local social service offices.

Projecting this figure to all persons in Virginia who received nursing home benefits for the first time in FY 1991, it is estimated that enrollees who own more than \$2,000 have a total of more than \$79 million dollars in assets (including property). This amounts to 24 percent of the total State expenditures on Medicaid nursing home benefits in FY 1991. This projection assumes that enrollees in the JLARC sample are representative of all enrollees statewide. Details of the projection are in Appendix B.

This is a conservative estimate because JLARC staff were unable to identify all of the property owned by the Medicaid enrollees. The property identified for this study was only in the enrollee's home locality. Property owned in other localities in Virginia or in other states is not included in the estimate.

The largest component of the assets were recipient property. At the time of program application, 80 percent of the recipients' resources consisted of real property — their homes or other developed and undeveloped land. To determine how these applicants were approved for Medicaid nursing home benefits, JLARC staff examined the eligibility files maintained at the local social service offices.

*Establishing Eligibility.* The most frequent route to Medicaid eligibility was through the use of allowable deductions to excess resources (Figure 7). In 27 percent of the cases, applicants reduced their resource levels to the program's \$2,000 threshold by

paying for outstanding medical bills for residential adult home and nursing home services that they had received or were currently receiving when they applied for Medicaid.

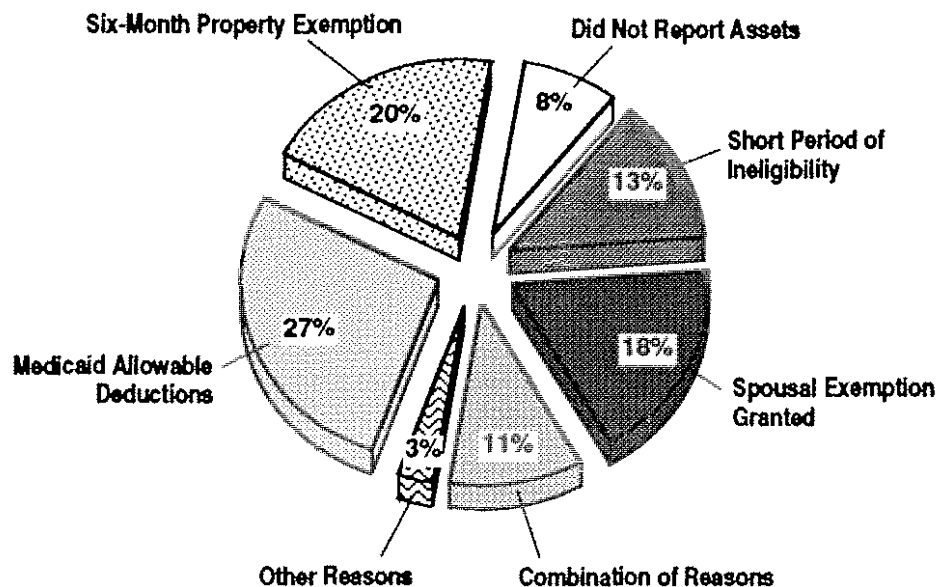
In an additional 20 percent of the cases, property was exempted for six months. An almost equal number of applicants with excess resources (18 percent) established eligibility because they had a spouse in the community. Another 13 percent had experienced a short period of ineligibility because of excess resources. Typically, these individuals were already in nursing homes but had not accumulated sufficient medical expenses to reduce their resources below the \$2,000 program limit.

**Verification of Property.** The Department of Social Services (DSS) is responsible for conducting Medicaid eligibility determinations. If a person owns property at the time of Medicaid application but does not qualify for an exemption, there is an incentive to "hide" the property from the Medicaid eligibility worker by refusing to report it. In Virginia, this incentive is made stronger because the State forces all applicants with non-exempt property to sell the real estate after six months.

Moreover, 57 percent of the DSS Medicaid eligibility workers that were interviewed for this study indicated that they only check to see if an applicant owns and has transferred property if it is reported. The consensus among this group was that the daily press of their caseloads makes it impossible to check property records on every applicant.

Figure 7

### Methods Used to Establish Medicaid Eligibility, Given Excess Resources



Source: JLARC staff analysis of recipient eligibility files in 14 local social service offices.

DMAS staff are aware that local eligibility workers are neither required nor able to verify property ownership in all cases. However, the agency has developed a quality control program to determine, among other things, the proportion of Medicaid recipients who establish eligibility without fully disclosing their real property. This program, which is reviewed by HCFA, meets federal requirements and indicates that the State has a low overall error rate—less than three percent. Based on FY 1992 data, DMAS reports that in only one of the 178 nursing home cases sampled, did DSS staff find that a recipient did not report property ownership.

In this study, JLARC staff focused its sample selection exclusively on persons who were applying for Medicaid nursing home benefits for the first time in FY 1991. Next, to determine if applicants were failing to report property, JLARC staff examined county and city land books for each sample member for the three-year period prior to their admission date. As Figure 7 shows, eight percent of the persons who were approved for benefits failed to report property which was later identified by JLARC staff. The median value of this unreported property as of 1991 was \$33,550.

It is important to note that the reasons that this property was not disclosed could not be determined. In some cases, the ownership of the property may have been in dispute. In others, the property may have been transferred to a spouse or dependent child. In such cases, disclosing the property would not have affected the recipient's eligibility status.

This difference in error rates may be the result of sampling techniques. As noted, DMAS is required to develop its sample from the universe of all Medicaid recipients. Thus, it is possible that new applicants for nursing home benefits are not fully represented in this sample. In light of this, it could prove beneficial to have the Clerks of Court routinely check property records for all persons who apply for Medicaid long-term care benefits.

***Recommendation (1).*** The General Assembly may wish to consider requiring the Clerks of the Court to conduct property checks for all persons applying for Medicaid benefits. These property checks should cover the three-year period prior to the date that the application for benefits was submitted. To facilitate these checks, the Department of Social Services should require each local office to send to the Clerks of Court, on a monthly basis, the names of new Medicaid applicants.

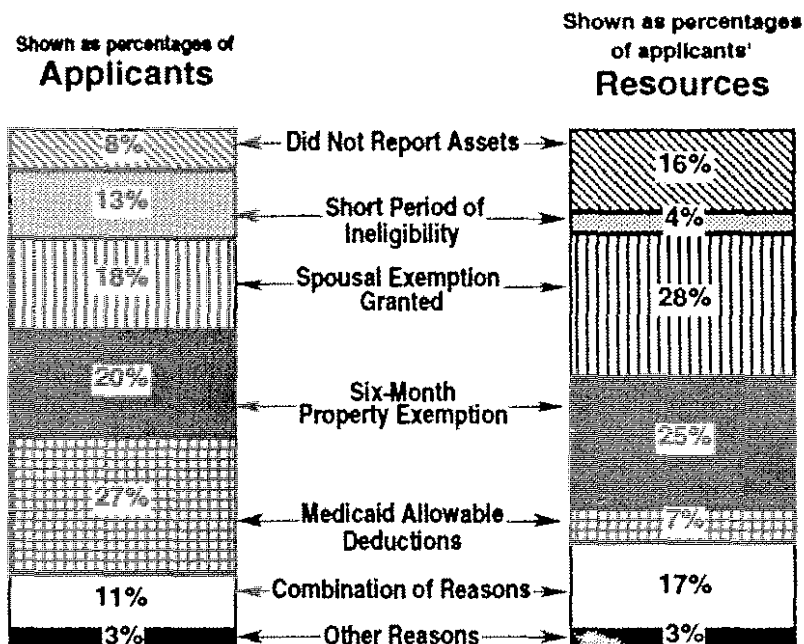
### **Most Resources Are Exempted During Initial Application**

Although most applicants use their excess resources to pay for their care, this type of resource disposition only accounts for nine percent of total assets identified for persons above the Medicaid resource limit (Figure 8). The State's six-month property exemption, as well as the exemption provided because an applicant had a spouse living in the community, accounted for 25 and 28 percent of the total resources, respectively. Approximately 16 percent of the total assets possessed by persons above the Medicaid resource limit were simply not reported and therefore did not impact their eligibility.



Figure 8

## Disposition of Resources for Medicaid Applicants Seeking Nursing Home Benefits



Source: JLARC staff analysis of recipient eligibility files.

These findings clearly indicate that the largest share of assets for persons who are above Medicaid's statutory resource limits are initially retained without affecting their eligibility for nursing home benefits.

### VIRGINIA'S MEDICAID ASSET TRANSFER RESTRICTIONS

Under current federal law, states must implement policies which deny program benefits to persons who transfer non-exempt assets within 30 months of applying for long-term care benefits. To comply with this law, Virginia has adopted a specific set of policies defining the conditions under which program applicants or recipients may transfer assets without penalty.

This part of the study addresses the fundamental question of whether individuals are sheltering assets to shift the cost of their nursing home care to the taxpayer. At the same time it is recognized that all cases involving asset shifting cannot be identified. Individuals who successfully hide resources from eligibility workers may have avoided detection in this study as well. However, because transfers can be legally conducted to

produce the same results, the number of people engaged in illegal unreported transfers may not be substantial.

In general, despite federal and State policies restricting the practice of asset transfers, a minority of recipients still find ways to give away resources and qualify for nursing home benefits. Moreover, unless there are changes made to federal and State regulations, it is likely that the magnitude of this problem will grow as persons become more knowledgeable about Medicaid eligibility policies or use the services of attorneys to assist them with the application process.

### Virginia's Asset Transfer Restrictions Meet Federal Requirements

Virginia's current policies regarding the treatment of asset transfers are based on federal statutory provisions authorized by MCCA in 1988 and the Omnibus Budget Reconciliation Act of 1989. Basically these laws prohibit any person who is either applying for or receiving long-term care benefits from disposing of resources for less than fair market value. Moreover, it restricts the spouse of someone who is institutionalized from transferring assets that were exempt at the time Medicaid application for benefits was made. The period of time covered by the restriction is 30 months prior to or after an application is submitted for program benefits.

Transfer Penalties. The penalty for conducting illegal transfers is the denial of eligibility for long-term care services. The period of ineligibility, according to federal law, begins in the month that the property was transferred. In Virginia, the actual length of the suspension of program benefits is determined by the uncompensated value of the transfer and the statewide average cost of nursing home care. Specifically, intake workers in Virginia calculate the period of ineligibility by dividing the value of the uncompensated transfer by the State's average monthly nursing home cost. Nonetheless, under no circumstances can this period exceed 30 months. An example of how this method is implemented is illustrated in the following case example.

*On January 1, 1992, Ms. Jane Doe is admitted to a nursing home because she suffers from Alzheimers Disease. In February, her two children decide to seek Medicaid nursing home benefits for their mother. However, before applying for Medicaid, they remove \$75,000 from her savings account and invest the money for themselves in several money market funds. When the eligibility worker identifies this transfer of assets, she first divides the total amount of the uncompensated transfer by the average private cost of one month of nursing home care ( $\$75,000 / \$2,230$ ). This establishes 33 months of ineligibility. Since the maximum period of ineligibility can not exceed 30 months, Ms. Doe will not be able to receive Medicaid until August of 1994.*

Some Transfers Permitted within 30 Months. Under the proper conditions Virginia allows recipients to transfer certain assets, as required by federal law. This includes property transfers by the nursing home recipient to: disabled sons or daughters;

siblings who lived in the home one year prior to the Medicaid recipient's nursing home admission date; or children who provided home care for at least two years before the recipient was institutionalized.

In general, the law requires persons who transferred property to receive adequate compensation or provide evidence supporting a position that the asset could not be sold at market value. Certain assets which are exempt or noncountable resources — personal effects, one automobile — can be transferred without penalty. Also, other transfers may be allowed if the applicant can prove that they were not made for the purpose of qualifying for Medicaid, or that denial of eligibility would pose an “undue hardship.”

### **Asset Transfer Restrictions Do Not Effectively Limit Transfers**

For this study, JLARC staff defined an asset transfer as any transaction involving a Medicaid's recipient's real property or liquid assets in which the resources were sold, given away, or used to purchase goods or services. To examine this practice, eligibility records, financial data, and property records were reviewed for a sample of 510 new Medicaid nursing home enrollees for FY 1991. In addition, the income levels for the universe of new nursing home enrollees were examined for five years prior to their receipt of Medicaid benefits.

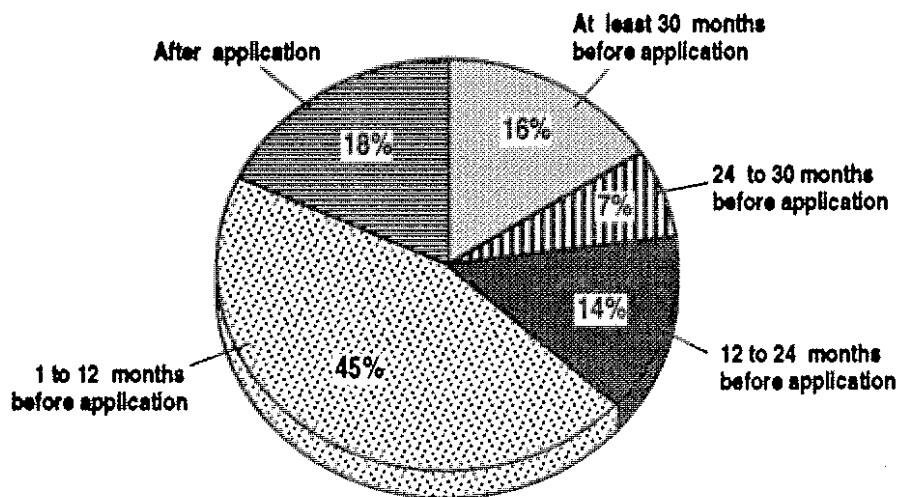
Based on the file reviews, JLARC staff determined that more than one-quarter of the persons sampled in this study transferred assets either before or shortly after receiving Medicaid nursing home benefits (Figure 9). The average value of the resources transferred by the sample members was \$22,747. When projected to the total number of persons in Virginia who were new Medicaid nursing home enrollees in FY 1991, it is estimated these recipients transferred approximately \$43 million dollars prior to or after they began receiving care (Appendix B). However, as will be discussed later, the majority of the transfers were conducted by recipients to either pay for a portion of their care or establish burial trusts.

*Time Period Assets Were Transferred.* Although current Medicaid law restricts transfers made within 30 months, this did not appear to be a factor in preventing this practice among applicants who decided to dispose of resources prior to seeking program benefits. Data from the file reviews indicate that recipients typically transferred their assets approximately six months prior to enrolling in Medicaid. Almost 77 percent of the transfers were conducted within two years of an applicant's decision to apply for Medicaid nursing home benefits (Figure 9).

In total, 84 percent of all the transfers were conducted within the 30-month time period prohibited by Medicaid law. In a number of cases (18 percent), persons transferred assets after they were approved for and receiving Medicaid nursing home benefits. In most cases, this resulted from the sale of a home that was placed on the market prior to applying for benefits.

Figure 9

### Time between Transferral of Resources and Application for Medicaid



Percent of applicants transferring assets = 27%  
Average value of assets transferred = \$22,747  
Total projected assets transferred = \$43,820,519

Notes: The sampling error for the proportion of persons who transferred assets is 4%. The average value of the assets transferred represents a stratified mean. The 95% confidence level for total resources transferred by this group has an upper bound of \$55,358,811 and a lower bound of \$33,584,515.

Source: JLARC staff analysis of recipient eligibility files.

### Most Resources Transferred through Routine Means Are Used for Care

Despite the 30-month prohibition on asset transfers, only four percent of the applicants who conducted such transfers within this time period were ruled ineligible for some length of time before they were later approved for Medicaid. Given this, a legitimate question is whether applicants are using creative approaches to legally divest assets as a means of establishing eligibility for Medicaid nursing home benefits.

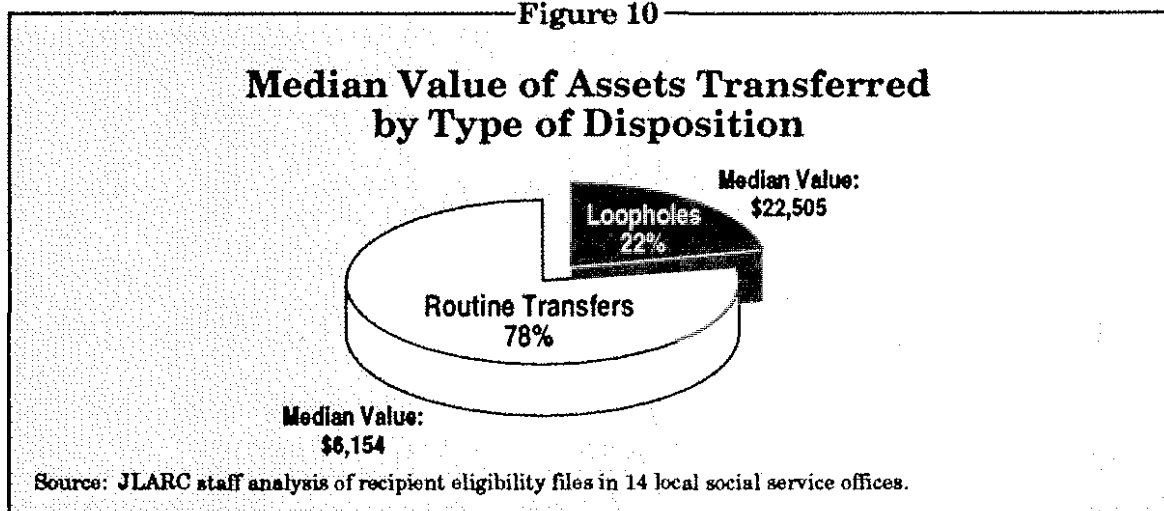
To address this question, JLARC staff reviewed the case files for the Medicaid applicants identified as having transferred property or assets. The objectives of this review were to determine how the eligibility workers evaluated the legality of the transfers and assess how the applicants' eligibility was affected.

***Classifying Transfers.*** As a part of this process, the study team classified transfers in either of two categories: "routine dispositions" or "legal loopholes." Transfers were generally defined as routine when conducted for the purpose of paying nursing

home care, medical bills, burial plans, or giving property titles to the spouse. The category of legal loopholes was used to define creative approaches in which the applicant's intent appeared to be to preserve assets while acquiring Medicaid nursing home benefits.

JLARC staff found that in 78 percent of the cases, recipients made routine transfers when establishing eligibility for Medicaid (Figure 10). However, these applicants had substantially less resources than persons relying upon the use of "legal loopholes." As shown, the median amount of resources for recipients who used a loophole in the law was more than three times higher (\$22,505) compared to those whose route to Medicaid was through more conventional means (\$6,154). This seems to suggest that applicants who have extensive resources are more likely to use creative strategies or "loopholes" to minimize their out-of-pocket nursing home expenditures.

Figure 10



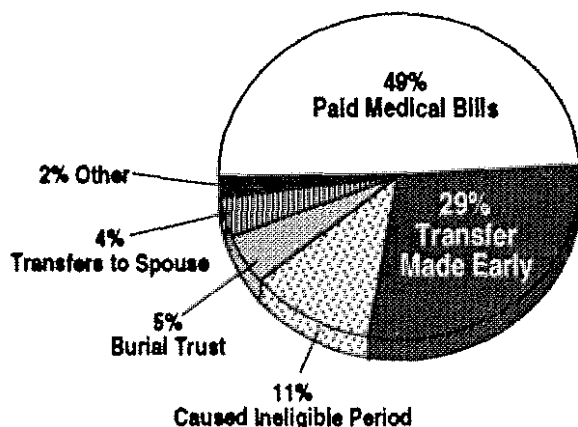
**Type of Routine Transfers.** Most of the applicants' resources that were transferred through "routine" strategies were used to pay medical bills or for previous nursing home care. As Figure 11 indicates, 49 percent of the resources transferred were used for this purpose. In these cases, the applicants usually had large sums of money in checking accounts. When eligibility workers investigated the cases, they discovered that the funds were encumbered to pay for care that had already been provided by either adult homes or nursing facilities.

Another 29 percent of the resources transferred had no impact because the applicant disposed of the assets far enough in advance to avoid any loss of eligibility. In many of these cases, the assets were transferred prior to July 1, 1988 and were therefore evaluated by the eligibility workers under the transfer rules established as a part of TEFRA.

The remaining 21 percent of these resources either caused a short period of ineligibility (11 percent), were used to purchase burial trusts (five percent), were trans-

Figure 11

### Nature and Impact of Routine Asset Transfers



Source: JLARC staff analysis of recipient eligibility files in 14 local social service offices.

ferred to the community spouse (4 percent), or were transferred through other means (2 percent).

In interviews with the local eligibility workers, concern was expressed about the money being used for burial trusts. Because Medicaid does not restrict the amount of money that can be used on properly drafted trusts, several of the workers interviewed thought this exemption was being abused. Among the sample selected for this study, evidence of such abuse could not be found. The average amount spent on burial trusts for this group of applicants was just over \$3,500. Nonetheless, DMAS staff point out that as long as there is a contract for the the specified burial expenses as identified in the trusts, the transfer does not affect eligibility.

### \$14 Million in Assets Legally Protected Using Medicaid Loopholes

Due to the complexity of Medicaid eligibility policy, there are a myriad of strategies that applicants can use to divest or shelter resources from the program. This review does not attempt to describe each of these strategies. Instead, the objective is to discuss some of the major strategies used by applicants included in this study.

In conducting file reviews and interviewing eligibility workers, JLARC staff identified a number of approaches that were used by Medicaid applicants seeking nursing home benefits. In some cases, the applicants paid attorneys to negotiate the eligibility process for them. In other cases, applicants appeared knowledgeable enough to apply for eligibility without legal counsel.

Based on the file reviews, it is estimated that applicants protected more than \$14 million dollars in assets when applying for nursing home benefits. Figure 12 lists

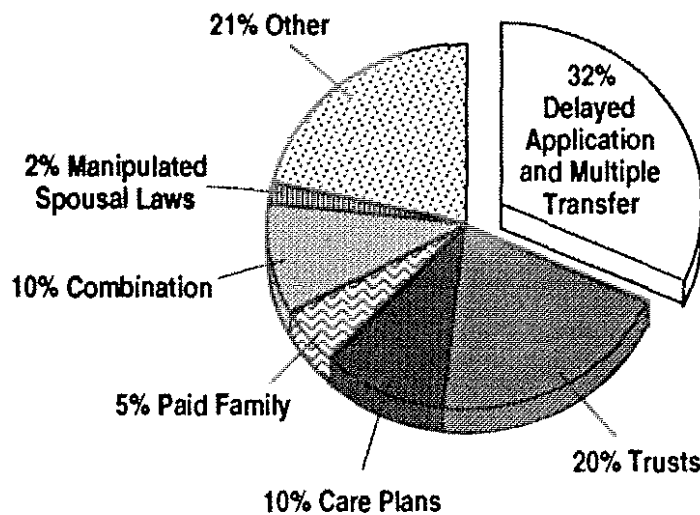
some of these approaches and indicates what proportion of the resources were transferred through each technique.

***Delaying Application After Transfer.*** One of the largest loopholes in Medicaid law is what is referred to as the "look-back" period. This provision of the Medicare Catastrophic Coverage Act (MCCA) defines the method that each state must use when calculating a period of ineligibility associated with an improper transfer. The law states that "The period of ineligibility [for illegal transfers] shall begin with the month in which such resources were transferred...." As described earlier, the period of ineligibility is calculated by dividing the value of the transfer by the State's average monthly nursing home cost.

The impact of this is that persons can give away assets, calculate the length of time for which they are ineligible, and then apply for Medicaid once that period has ended. Each period of ineligibility is determined by dividing the total value of the assets transferred by the average nursing home costs in the State. Among the cases considered loopholes, this strategy accounted for 32 percent of the total resources transferred.

Figure 12

### Total Resources Transferred by Type of "Loophole" Used



Applicants using loopholes = 8%  
Average resources transferred = \$25,265  
Total projected transfers = \$14,421,457

Notes: At the 95% confidence level, the sampling error for the proportion of people who used loopholes is 2%. The reported average amount transferred is a stratified mean. The total projected assets transferred was calculated at a 95% confidence interval. The total transfers were estimated to range between \$19,689,930 and \$9,818,227.

Source: JLARC staff analysis of recipient eligibility files in 14 local social service offices.

There are a number of variations to this approach. For example, a person can transfer a certain amount of assets each month. This will result in separate periods of ineligibility starting with each month that a transfer was made. However, because the transfers are made in consecutive months, the individual's ineligibility periods will begin to overlap thereby mitigating the impact of the penalty. The following case example from the JLARC review of local eligibility files demonstrates how this works.

*On January 23, 1991, an individual submitted an application for Medicaid nursing home benefits. Because she was married and already in a nursing home, the local eligibility worker conducted a resource assessment. This assessment revealed that the client and her husband had been transferring assets to their daughter while she was institutionalized. The records showed that in each month from November of 1989 to April of 1990, the following assets were transferred.*

<u>Date</u>	<u>Amount</u>	<u>Period of Ineligibility</u>
November 89	\$10,900	4.8 months
December 89	\$10,000	4.5 months
January 90	\$ 9,350	4.2 months
February 90	\$ 7,000	3.1 months
April 90	\$ 3,000	1.3 months

*In total, the eligibility worker indicated that \$40,250 was illegally transferred. These transfers established almost 18 months of ineligibility. However, because they were conducted in consecutive months, when the applicant applied for nursing home care in January 1991, the periods of ineligibility had already passed.*

In response to a growing concern among states regarding this strategy, the Health Care Financing Administration (HCFA), disseminated a "Medicaid letter" permitting states "to adopt reasonable interpretations of the [federal] transfer statute in terms of how to treat multiple transfers." The letter contains language giving states the discretion to count multiple transfers as a single transaction provided the applicant had the full amount of the resources available at the time the first transfer was made. During the course of this study, DMAS staff indicated that a proposal for adopting such a regulation was being prepared for review by the Director. Such a regulation could potentially result in an estimated \$4 million in annual savings for the Medicaid program.

**Recommendation (2).** The Department of Medical Assistance Services should use the authority recently granted by the Health Care Financing Administration to adopt a State regulation permitting eligibility workers to count multiple transfers as a single transaction.

Use of Irrevocable Trusts. Approximately 21 percent of the resources diverted by Medicaid applicants through loopholes were accomplished with irrevocable trusts. A trust is a legal document in which an individual agrees to transfer assets to another party who is to manage the trust for all other beneficiaries. A trust can be revocable, meaning



it can be changed by the donor at anytime, or they can be drafted as irrevocable. Assets placed in an irrevocable trust generally cannot be reclaimed by the donor in any manner that is not specified in the trusts. Also, the trust can be discretionary, which indicates that the trustee has right to distribute the benefits.

Prior to 1986, individuals routinely established irrevocable, fully discretionary trusts as a means of sheltering resources from Medicaid. Because the document was drafted to be irrevocable, states generally had to rule that the donor no longer had access to the assets placed in the trust. This prevented states from counting these assets when determining eligibility.

In 1986, Congress changed this law by stating that the assets of an irrevocable trust would be countable if the trustee has full discretion over the distribution of the trust benefits and it was funded by a Medicaid applicant or his or her spouse during their lifetime.

Unfortunately, states are finding that trusts are still being used to shelter resources from the program despite the new law. According to research conducted by Systemetrics and LTC Incorporated, attorneys are now devising a number of different types of trusts which states are finding impossible to invade.

Presently, Virginia considers only those trusts which are irrevocable and non-discretionary as inaccessible to the donor and therefore not countable as an asset. Moreover, a transfer of assets made to any type trust is considered disqualifying if made within the 30-month period prior to eligibility.

The file reviews indicated that seven percent of recipients are still able to use trusts as a means of passing their assets on to their heirs. In one case, an individual was able to receive nursing home benefits because she only had "life interest" in her home which was valued at \$150,000. The home was placed in a trust by her husband through the use of a will listing the children as beneficiaries. Although the trust was fully discretionary, Medicaid could not count the assets because the trust was not to be funded until after the donor died. When the eligibility worker questioned the children about the trust and whether any money would be used to support their mother, she received a letter from an attorney which included the following comments.

*Unfortunately, this trust is of no value to Ms. Doe. She has no ownership in the trust which is composed of significant real estate [\$150,000] and approximately \$2,000 cash. Under the terms of the trust, the real estate can not be sold for Ms. Doe's benefit. I have informed [her son] that he would be breaching his fiduciary duty to the trust if he expended any of the modest funds in the bank for his mother's benefit.*

There are a number of different strategies that can be pursued through creatively drafted trusts. In another case identified in the file reviews, an individual established a trust with her attorney as the trustee. Part of the language in the trust gave the trustee authority to distribute income to the donor of the trust as long as she "was not

a resident of any long-term care nursing facility or other medical care facility eligible to receive reimbursement for care under Medicaid.” Because this clause removed the trustee’s discretion to pay benefits to the donor of the trust when she entered a nursing home, Medicaid could not consider the resources of the trust available to her.

Also, the trust was drafted in such a way to allow the Medicaid applicant to make gifts to the trust. This provision was used by the applicant to make monthly gifts totaling \$34,000 before she applied for Medicaid. When this individual applied for Medicaid, her lawyer sent the following letter to an eligibility worker who raised questions about the legality of the transfers.

*I am happy to confirm that the attorney general has concluded that the trust [for his client] is irrevocable and that it does not form a countable resource in, or furnish deemed income to, Ms. Doe’s estate. Enclosed please find a computer printout showing the status of Ms. Doe’s irrevocable trust.... You will note that there are series of \$4,000 deposits and one \$2,000 deposit. As we discussed, it is our position ... that Ms. Doe retained the right to add property to the trust by additional gifts. I believe each gift made Ms. Doe ineligible for Medicaid reimbursement ... for [a period beginning with] the month in which the transfers were made. [Those] periods of ineligibility have all expired.*

Purchase of Care Plans. Another loophole in Medicaid policy is the exemption placed on term life insurance. This type of policy is not counted as a resource because it has no cash value. Thus any benefit paid by the policy accrues to the beneficiary and not the Medicaid applicant.

Three of the eligibility workers interviewed for this study indicated that applicants are beginning to purchase expensive term life insurance policies, and naming as the beneficiaries their originally intended heirs. Under federal and existing State policy, the transfer can not be restricted because the applicant purchased an exempt asset (term life insurance), and received adequate compensation of goods or services for the transfer. This practice accounted for 10 percent of all the resources transferred through loopholes. One such case identified in the file reviews is described below:

*On March 3, 1991, Mr. John Doe sold his home for \$45,700. After settlement costs were made, Mr. Doe cleared \$42,761. Later that day, Mr. Doe took out a term life insurance policy with a single premium payment of \$24,750. It was scheduled to pay a benefit of \$26,750. The beneficiary of the policy was his daughter. After using the other \$20,000 to pay an old nursing home bill, Mr. Doe applied for and received Medicaid nursing home benefits on March 5th — two days after passing \$24,750 on to his daughter through the life insurance policy. To ensure that the insurance company would not lose any money if Mr. Doe died within a short period after the policy was written, the policy stipulated that benefits would not be paid until at least two years from the date that the plan went in force. This gives the insurance company the time to invest the premium of \$24,750 and collect two years worth of interest.*

In the case described below children of one Medicaid applicant used this loophole to gain access to their mother's resources before she entered a nursing home. This case example was provided by central office staff at DSS.

*On June 23, 1992, a social worker in one local office received a nursing home screening referral for Ms. Doe. After visiting the home and meeting with Ms. Doe, the social worker stated that she was "incompetent but ... if additional assistance were provided to her she could probably remain in her home for some time." However, Ms. Doe's children discovered that term life insurance policies were not a countable resource and purchased five separate policies for a total of \$29,520. On each policy, the children named themselves as the beneficiaries. The social worker filed a case against the children for exploitation. When the case went to court, the judge appointed Ms. Doe's son as her legal guardian and ordered the eligibility workers to grant Ms. Doe coverage for Medicaid nursing home benefits.*

Staff at DMAS and the DSS contend that federal law does not require states to allow transfers made for the purpose of purchasing term life insurance. Because the money is used to purchase a policy that provides no benefit to the applicant, DMAS staff feel the transfers should be considered disqualifying. One staff member stated that the agency currently allows these transfers based on the advice of legal counsel from the Attorney General's office.

When asked about this issue, staff in the Attorney General's office restated the legal opinion that the purchase of term life insurance is not an uncompensated transfer because the policy pays a benefit that exceeds the cost of the premium. According to one attorney, the fact that the benefits are actually paid to someone else is not relevant.

One way to address this problem would be to give DMAS the authority to deny Medicaid benefits to anyone who purchased, within 30 months of Medicaid application, a term life insurance policy which did not have a minimum benefit-to-premium ratio.

This legislation would not prevent an applicant from purchasing this type of policy. It would simply define whether the policy represented adequate compensation of goods or services as measured by the ratio of policy benefit to policy cost. As shown in this study, the common feature of the policies used to transfer assets are extremely low benefit to premium ratios. If the ratios were higher, the insurance companies would simply not make these policies available to elderly persons because of the risk of loss on such policies.

**Recommendation (3).** The General Assembly may wish to adopt legislation giving the Department of Medical Assistance Services the authority to count the resources used by Medicaid applicants to purchase term life insurance policies which have benefit to premium ratios that are lower than an established threshold. The time period in which these transfers can be regarded as inadequate compensation should be 30 months prior to the date that the person applies for Medicaid nursing home benefits. The State Bureau

**of Insurance should assist in the development of an appropriate benefit to cost ratio standard.**

*Manipulating Generous Spousal Impoverishment Standards.* As noted earlier, MCCA made significant changes to the resource standard for married couples to prevent the community spouse from being impoverished by the institutionalized spouse's nursing home costs. Because the method for determining the community spouse's resource standard is very favorable, a number of strategies can be used to divert additional assets away from Medicaid.

Two percent of the resources disposed of through loopholes in this study were related to manipulation of spousal impoverishment rules. The most common strategy was to increase the couple's assets just before their total countable resources were determined. Once this was done, a large portion of the Medicaid applicant's share of the assets was used to purchase exempt resources or pay outstanding bills. The following case example identified in one office illustrates this approach.

*Mr. and Ms. John Doe met with an eligibility worker to determine if Ms. Doe could receive Medicaid to pay for some of her nursing home costs. At the time of this resource assessment, the couple's total assets were \$33,748. Dividing this figure by two created a community spousal share of \$16,874. This amount was subtracted from the couple's total assets leaving \$16,874. However, after the total resources available for Ms. Doe were determined, the couple indicated that the following expenses were paid:*

<i>-- pre-paid funeral for space items (casket)</i>	<i>\$ 5,061</i>
<i>-- loan on the family car was paid</i>	<i>1,044</i>
<i>-- remaining mortgage on home was paid</i>	<i>5,219</i>
<i>-- burial plot established for both persons</i>	<i>5,000</i>
<i>-- total deductions from Ms. Doe's share</i>	<i>\$16,332</i>

*Based on these deductions, the eligibility worker determined that of the couple's total resources of \$33,748, only \$550 were available to defray the cost of Ms. Doe's nursing home care.*

*Other Strategies.* Some of the other strategies used ranged from paying family members for providing care, to seeking court orders giving the spouse the right to claim all the assets of the person institutionalized. The specifics of the latter case are discussed in the following case example:

*Mr. John Doe was admitted to a nursing home in 1988 after being rendered comatose from an accident. After paying for his care for two years, his wife sought the assistance of an attorney to determine if her husband was eligible for Medicaid. At the time she visited the attorney, the couple's assets included \$98,000 in property and \$58,000 in cash. Ms. Doe's attorney went to court seeking an order that would give his*

*client exclusive ownership of the couple's assets. The judge granted this order on July 31, 1990. That same day Ms. Doe's attorney notified the eligibility worker that Mr. Doe was no longer above the Medicaid resource limit and as a result was eligible for nursing home benefits. Mr. Doe was then approved for Medicaid benefits.*

**Recommendation (4).** The General Assembly may wish to amend the *Code of Virginia* by specifically prohibiting the courts from issuing orders which allow individuals the right to claim the assets of other institutionalized persons without their legal consent for purposes of avoiding payment of medical expenses.

### **Analysis of Tax Data Not Conclusive**

Using the eligibility and property records of Medicaid applicants to examine the question of asset transfers has its limitations. Chief among these is the problem created when Medicaid applicants do not give an accurate accounting of their assets. In such cases, an analysis which focuses on data collected at eligibility will understate the magnitude of the resource shifting which is occurring. One concern of the study team was that eligibility workers would not have a complete picture of the applicant's financial assets.

As noted earlier, JLARC staff attempted to address this problem by collecting income data for all new Medicaid enrollees during the five-year period prior to their date of admission. While there was a downward trend in the number of elderly persons who filed State taxes prior to receiving Medicaid, the results do not conclusively demonstrate evidence of substantial asset shifting.

*Six-Figure Incomes in Medicaid.* A closer look at the income data does underscore the potential for middle- and upper-income individuals to gain access to the program's benefits. These data indicated that four individuals had incomes in at least one of the five years preceding their enrolling in Medicaid of more than \$100,000. Two of these cases are discussed below:

*In 1987, three years before receiving Medicaid, one individual reported a total income to the State of more than \$600,000. By 1990, this figure had been reduced to \$22,000. During FY 1991, the Medicaid program paid a nursing home over \$14,000 for the care provided on this person's behalf.*

\* \* \*

*In 1987, an individual reported a total income of just under \$200,000. In the three following years, this person's total income never dropped below \$140,000. In the year immediately before enrolling in Medicaid, 1990, a total income of more than \$300,000 was reported. In FY 1991,*

*the Medicaid program paid a nursing home more than \$11,000 for the care provided on this person's behalf.*

### **Is Estate Planning for Medicaid Growing?**

Because some people do not disclose transfers, identifying the precise magnitude of the problem remains elusive. Another possible indicator of the level of this activity is the number of Medicaid applicants who are represented by attorneys during the eligibility process. Because of the complexity of the Medicaid laws, persons with significant assets to shelter will require the services of attorneys.

During the file reviews, JLARC staff saw evidence that attorneys are becoming involved in the process but apparently for only a minority of cases. When eligibility workers were asked to indicate how often they received calls from attorneys for information on Medicaid eligibility policy, only three of the workers indicated that they received such calls either "often" or "very often." The majority (seven) stated that they must work with attorneys only "occasionally." The remaining four workers indicated that they either rarely (three) or never (one) received phone calls from attorneys. One worker's comments seemed to be typical of most opinions expressed about attorneys and asset transfers.

*We get calls from attorneys only occasionally. We do not see a lot of transfers. It happens occasionally, but it is by no means a regular part of our work. I did have one applicant protect \$90,000.*

Still a few of these workers were convinced that the type of applicant for Medicaid-supported nursing home care has changed. Workers in two rural counties stated:

*About 50 percent of the applicants for nursing home care in this county transfer assets to gain access to Medicaid. We are getting a totally different client than we used to. They often have a lot of resources.*

\* \* \*

*We get quite a few people transferring assets. If a lot of money is involved, the children will work to shelter the assets.*

The mixed conclusions of the eligibility workers and the observed incidence of cases of asset transfers among Medicaid enrollees does not provide convincing evidence that the problem is growing. However, as the population needing nursing home care grows, and applicants for Medicaid nursing home benefits learn more about program eligibility policies, a substantially higher number of individuals will likely begin to use certain strategies to gain access to Medicaid while protecting their assets for their heirs.

*The Role of Eligibility Workers in Estate Planning.* One criticism that has been levied by some analysts is that eligibility workers will counsel applicants in ways to shelter resources in order to establish eligibility for nursing home benefits. Because of a concern about this problem in Virginia, the Commissioner of the Department of Social Services has taken steps to minimize the involvement of eligibility workers in estate planning.

Through an information bulletin distributed to each local office in March 1992, the Commissioner required workers to limit their response to requests for information about "hypothetical situations" concerning Medicaid eligibility. According to the Commissioner, these types of situations are often presented by attorneys and family members so that specific actions can be taken to transfer assets prior to the submission of an application.

In field interviews with intake workers, the study team asked each respondent to indicate how these types of cases had been handled prior to the release of the Commissioner's information bulletin. Almost 65 percent of those interviewed stated that they either rarely (50 percent) or never (14 percent) responded to hypothetical situations which required an explanation of how certain resources could be sheltered. These respondents stated that the agency's new policy did not represent a change from the way such cases have historically been handled.

The remaining 35 percent of those interviewed stated that they responded to these hypothetical situations either often or occasionally. One worker stated the following:

*I used to give out information from the manual and explain hypothetically how resources could be legally reduced. I would still advise a person to come in and submit the proper documentation.*

Another worker understands the intent of the policy but believes it conflicts with the basic objectives of the agency's policies on resource assessment. She stated:

*With the resource assessment, the worker is required to make a pre-application determination of eligibility. If the result of the assessment is [that the applicant has] excess resources, a notice of denial is mailed along with a copy of Medicaid policy on allowable deductions. I will highlight deductions and answer questions about what the applicant can do to establish eligibility through reducing assets.*

DSS central office staff indicated that the resource assessment policies do not conflict with the instructions in the Commissioner's letter. One staff member stated that the eligibility workers should not be "highlighting deductions" for applicants under any circumstances. To further emphasize the agency's policy regarding the issue, the Commissioner's information bulletin has been added to the policy manual.

## **Additional State Options for Slowing Asset Transfers Are Limited**

Although Virginia has a vested interest in the issue of Medicaid asset transfers, like other states there is a limit to the action which can be taken with legislation to discourage this practice. Federal laws governing asset transfer dictate to the states what types of transfers have to be allowed and those that can be considered disqualifying. For the states to effectively address the problem posed by asset transfers, the Congress will have to modify the restrictions placed on the states. The General Assembly may want to petition the Congress for such changes.

Until changes are enacted by Congress, states must look for other means to reduce the impact of transfers on Medicaid spending. For example, Connecticut is using a planning grant to encourage individuals to buy long-term care insurance that would be commensurate with their assets. When the insurance is exhausted, the individual can qualify for Medicaid without losing their previously insured assets. Unfortunately, unless changes are made to federal law which make it more difficult to transfer property and still receive Medicaid, this approach is unlikely to have an impact on the incidence of Medicaid asset transfers. As one expert noted, "Why should someone pay \$2,000 to \$4,000 per year for a long-term care insurance policy, when, for less money, they can hire an attorney, divest their assets, and qualify for Medicaid?"

*Clarify State's Authority to Invade Trusts.* The State could clarify its laws regarding the ability of agencies to invade certain types of trusts. In Virginia, §55-19.(D) of the *Code of Virginia* gives DMAS the authority to petition the court for reformation of trusts that provide income to persons who receive public assistance. However, this provision seems to exempt "spendthrift" trusts. These are usually third party trusts which have a value that is less than \$500,000.

Under the "spendthrift" trust provision, an individual may establish a fully discretionary trust that pays resources to a disabled person in a nursing home. If the trust contains clauses that prevent the use of trust benefits for payment of medical expenses, the beneficiary can apply for and receive Medicaid without using the resources of the trust because the resources are not considered to be available to the applicant.

Once eligibility is established by the trust beneficiary and Medicaid payments are made on his behalf, §55-19(D) of the *Code of Virginia* gives DMAS the right to seek reimbursement by petitioning the court to have the trust reformed and its benefits made available for collection.

However, a key provision of that statute — §55-19.2 — prohibits the judge from ordering the trustee to repay Medicaid if the beneficiary has a "medically determined physical or mental disability which substantially impairs his ability to provide for his care...."

This language, which was added in 1990, appears to bar the State from collecting from these trusts despite other provisions directing the State to do so. As a result, the Attorney General's office has consistently advised DMAS to refrain from petitioning the court to make the resources of these trusts available. One State attorney



familiar with this issue feels that the General Assembly needs to pass legislation which clarifies the intent of §55-19(D) as it relates to "spendthrift trusts."

**Recommendation (5).** The General Assembly may wish to memorialize the United States Congress through joint resolution to place tighter restrictions on Medicaid asset transfers. This petition should request that the limit on transfers be extended to five years prior to eligibility and require states to calculate the period of ineligibility for illegal transfers beginning with the date that the applicant applies for and meets the level-of-care criteria for nursing home care.

**Recommendation (6).** The General Assembly may wish to pass legislation which clarifies whether §55-19(D) of the *Code of Virginia* gives the courts the authority to reform "spendthrift" trusts established for persons who are receiving Medicaid nursing home benefits.

### VIRGINIA'S SYSTEM FOR IDENTIFYING RECIPIENTS' ASSETS

Before the legality of any asset transfers can be evaluated, the type and amount of the transfer must be identified. Federal law requires all states to use an Income Eligibility Verification System (IEVS) to conduct intake and regular redeterminations of participant eligibility for federal public assistance programs. One objective of the IEVS system is to minimize cases of fraud by providing computer matches of Medicaid recipient files with various federal databases which contain income data.

The Virginia Department of Social Services (DSS) is responsible for organizing IEVS in the Commonwealth. Working with a number of State and federal agencies, DSS coordinates the collection of financial and some personal property data on each applicant for Medicaid benefits. Each major step in the data retrieval process is discussed below:

- Step One. The long-term care intake worker enters the Social Security number (SSN) of each person that applies for Medicaid nursing home benefits into a computer which is linked to the State's mainframe system.
- Step Two. Computer programmers at DSS' central office open the file of SSNs and create a database on tape. This process is repeated every seven days.
- Step Three. A copy of this tape is sent to all of the federal and State agencies that participate in IEVS. This includes the Virginia Employment Commission (VEC), the Department of Motor Vehicles (DMV), and the IRS. Because of their workload, some agencies like the IRS and DMV receive a tape on a monthly basis.
- Step Four. These agencies merge onto the tapes any financial or personal property information that is identified for each applicant and send the tape back to DSS' central office.

- Step Five. For each SSN number for which a match was identified, DSS staff develop a benefits impact statement and mail a hard copy report to the relevant intake worker.
- Step Six. The eligibility worker reviews the hard copy report and makes a determination about the accuracy of the information that was submitted on the application.

### Medicaid's Income Verification System is Not Timely

In structured interviews with eligibility workers, JLARC staff asked these workers to discuss their use of IEVS. Workers in 11 of 14 offices thought IEVS was not a cost-effective method of detecting potential cases of fraud. The major problem with the system is the time lag associated with getting some of the key data elements.

IRS Data is Late Arriving. This problem is most common with data on applicants' interest earnings from the Internal Revenue Service (IRS). This information is important because it can be used to identify whether applicants have reported all of their income-producing assets. However, the eligibility workers complain that this information can take from two months to one year to reach their desks. They point out that by the time this information arrives, eligibility determinations have already been made. Some of the statements made by the workers concerning this problem are listed below:

*As a preventive measure IEVS is not effective. There is a lag on most data provided through IEVS. IEVS comes in after the case has already been processed. IEVS is more effective for checking the accuracy of reported information when the client is already in the nursing home.*

\* \* \*

*IEVS is not that much help. Data from IEVS comes too late usually to prevent a person from getting Medicaid who does not report all assets.*

\* \* \*

*IEVS is regarded as a secondary piece of evidence because it is not timely enough to be a part of the initial application process.*

Most of the eligibility workers interviewed for this report attempt to minimize this problem by checking each application that has been processed against IEVS when the data arrives. If there is an unexplainable discrepancy between the data sources, the workers will investigate the case. At least three of the workers interviewed complained that their caseloads prevent them from checking all cases. A worker in one office commented that checking each application against IEVS is not a priority of the office.

DSS staff recognize the problem with the timeliness of the data but indicate that not much can be done to improve the response time of agencies like the IRS. According

to one staff member, DSS creates the tape used to conduct the match on a weekly basis. However, because of the workloads of the IRS and DMV, it is not feasible to send them a tape once per week and expect them to process the match and return the data to DSS. For this reason, these agencies will receive a tape of Social Security numbers only once a month.

Obviously, the Social Security numbers for persons who apply for Medicaid at the beginning of the month will not be included in the tape which the IRS and DMV receives. This means that at least an additional 30 days will pass before an attempt is made to determine the interest earnings and number of automobiles owned by these applicants.

DSS is presently working with a number of agencies that participate in IEVS to develop on-line access for each eligibility worker. Staff indicate it is unlikely that the IRS will provide this type access to its confidential tax files. However, DSS could request that IRS permit a DSS liaison to work with IRS in reviewing tax data.

*Time Lags in Data.* Another problem with IEVS is that when the financial information does arrive, it is often outdated. For example, if a person applies for Medicaid in January of 1992, the eligibility worker will typically receive IRS interest income data for 1990. This information is still useful, however, because it can identify assets that may have been disposed of by the time the person applied for Medicaid in 1992.

The problem with the current procedure is that it requires the eligibility worker to check each case to determine if any discrepancies can be explained by the applicant. Because IEVS provides so much information that needs to be verified, some workers stated that they have no time to conduct the investigation. DSS could reduce this problem by requiring workers to check only one particular type of financial data — interest income — for long-term care cases. This would focus the verification process on the type of information that is most likely to capture any transfers of liquid assets.

***Recommendation (7).*** The Department of Social Services should limit the IEVS data which eligibility workers are required to check for long-term care cases to the financial information reported by the IRS. All other types of verification for data that are not current should be left to the discretion of the eligibility workers. DSS should also explore the possibility of establishing a liaison position with the IRS.

## CONCLUSIONS

There is a growing concern that a number of Medicaid recipients are using “loopholes” in federal and state laws to gain access to the program’s benefits while preserving resources for their heirs. These strategies, while legal, effectively undermine the basic intent of Medicaid — to increase access to health care for persons who are poor.

This study found that more than one-quarter of those who apply for Medicaid nursing home benefits transfer assets either prior to or just after enrollment in the program. However, the majority of these transfers are conducted by applicants to pay medical expenses or a portion of their care.

A small number of applicants are using "loopholes" to shift the cost of their care to the taxpayers while preserving assets for their heirs. If this practice is to be stopped, both the State and federal government will have to change the laws and regulations which govern asset transfers.

Unrelated to this are federal Medicaid laws which require states to exempt the real property of applicants at the time they initially apply for nursing home benefits. This allows more than a third of all program applicants to be approved for Medicaid while owning substantial resources.

A major question concerning the Medicaid programs in most states is whether they are recovering a portion of these resources when the exemptions are lifted. The next chapter in this report examines the issue of estate recovery in Virginia.

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### III. Estate Recovery

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Because of federal eligibility laws which exempt certain assets when calculating Medicaid's allowable resource limits, a significant number of long-term care recipients can receive Medicaid support while retaining sizeable assets. Typically, the largest excludable asset is the recipient's home. As a result, many Medicaid recipients whose primary assets are their homes have not had to transfer property to protect it for their heirs.

Recognizing this, federal regulations provide states with the authority to establish programs to recover the costs of some of Medicaid benefits paid for certain groups of recipients. Specifically, this authority allows states to recover a portion of the expenses incurred in providing nursing home care.

In this sense, estate recovery programs require Medicaid recipients whose primary assets are their homes to contribute toward the cost of their long-term care in the same manner required of recipients whose assets are more liquid (e.g., stocks, bonds, and cash). Unlike the payments made from liquid assets, however, payments from the home's equity are deferred until the recipient and his or her spouse and children no longer need the home. Without an estate recovery program, if the nursing home resident dies before the house is sold, the home may pass to the resident's heirs without any of the assets being used to defray the cost of the Medicaid benefits paid on the nursing home resident's behalf.

In contrast to the asset transfer restrictions, estate recovery programs are not required but can be implemented at the option of the states. A number of states have established successful estate recovery programs, thus enabling them to substantially defray the costs of providing nursing home care.

The State of Virginia, however, has no formal, proactive estate recovery program. DMAS officials maintain that an estate recovery program would not be cost beneficial due to certain provisions of the State's 209(b) status that allow the State to apply more restrictive eligibility criteria. However, JLARC staff have found that, even with the more restrictive eligibility criteria, the State could potentially recover a significant portion of Medicaid nursing home payments if it developed a formal recovery program.

#### THE ISSUE OF ESTATE RECOVERY

As noted earlier, if certain individuals are living in the home of a person seeking Medicaid coverage of nursing home benefits or the applicant expresses an intent to return home, federal law prohibits states from treating the primary residence as a countable resource. States can, however, recover the costs of Medicaid nursing home care from the

recipient's property when the aforementioned circumstances no longer apply. Therefore, in the absence of an estate recovery program, states lose the ability to ensure that all of the resources available to Medicaid recipients are used to offset the cost of their care.

### **Medicaid Property Exemptions Granted To Prevent Hardships**

Federal eligibility laws exempt a number of assets from initial eligibility calculations. As mentioned, one major exclusion is the applicant's primary residence. One reason this exemption is granted is to allow the applicant's spouse or dependent children to have continued use of the home. As long as these individuals live in the home, the residence will not be treated as a countable resource. Once they are no longer using the residence, the State can remove the exemption and require that the house be sold to cover the cost of nursing home care.

A second reason that an exemption can be granted is that the applicant may express an intent to return to the home. In many states, this exemption will remain in place until the recipient either returns home or dies in care. In the latter case, the Medicaid agency can recover the benefits that were paid for nursing home care by forcing a sale of the property.

### **Federal Law Permits States to Recover Cost of Care**

Current State authority for implementing estate recovery programs comes primarily from TEFRA. As previously noted, the Boren-Long amendment of 1980 was a first step in providing the states with the authority to limit the ability of individuals to transfer assets in order to qualify for Medicaid. Because this legislation contained loopholes pertaining to the transfer of exempt assets, section 132 of TEFRA was enacted. In addition to tightening transfer of asset restrictions, this legislation authorized states to place liens on the property of living Medicaid recipients and to recover from the estates of deceased recipients. The stated objective of the Congress in enacting this legislation was as follows:

...to assure that all of the resources available to an institutionalized individual, including equity in a home, which are not needed for the support of a spouse or dependent children, will be used to defray the costs of supporting the individual in the institution. In doing so, it seeks to balance the government's legitimate interest in recovering its Medicaid costs against the individual's need to have the home available in the event discharge from the institution becomes feasible.

TEFRA provides states with two methods to help recover resources from recipients to defray the cost of nursing home care: (1) the placement of liens on the property of Medicaid nursing home recipients; and (2) the use of claims to recover from the recipient's probated estate. According to the Health Care Financing Administration, 11 states currently use liens to recover the cost of Medicaid nursing home care.

*Lien Authority.* States may place liens on the real property of institutionalized Medicaid beneficiaries for whom the state has determined that institutionalization is permanent. If a lien exists, the property holder must first satisfy the lien before the property can be sold or transferred.

It is important to note that if the nursing home resident has a spouse or child who resides in the home, a lien may be attached but it can not be foreclosed until these individuals no longer need the house. Further, if the recipient returns to the home, the lien must be removed. These limitations are designed to prevent undue hardship on the Medicaid recipient's family. While the constraints on the placement of liens have discouraged many states from utilizing their lien authority, this option to attach liens enhances a state's ability to recover some of the costs associated with providing expensive Medicaid nursing home benefits.

*Estate Recovery Authority Through Claims.* States can also defray the cost of nursing home care by placing claims against recipients' property after their deaths. Under this option, the state files a claim against the estate of a deceased Medicaid long-term care recipient for the cost of the benefits provided. As with the placement of liens, however, recovery cannot be made until the spouse or any surviving children under 21 or who are blind or disabled no longer need the home.

The effectiveness of this approach is dependent on the state's ability to identify and file the claim against the probated property of the deceased recipient. The obvious disadvantage of using claims is that they do not legally bind the recipient's surviving spouse or children to use the property to repay the state for benefits paid unless the property is probated. To avoid probate, a surviving spouse can simply sell the property after the institutionalized spouse dies and pass on the proceeds of the sale to his or her heirs.

### Equity Issues Surrounding Estate Recovery

In providing recovery authority to the states, the federal government recognized that using a recipient's assets to recover benefits correctly paid on his or her behalf could serve as a potentially large source of non-tax revenue to fund the Medicaid program. However, monetary benefit is not the only factor that should be considered in determining whether or not an estate recovery program should be developed. There are also equity issues surrounding estate recovery.

Many contend that the failure of states to attempt to recover from the estates of deceased Medicaid recipients violates the fundamental principles which should guide the distribution of benefits in any social welfare program. Often referred to as the concepts of horizontal and vertical equity, these principles hold that any criteria used to identify who will benefit from a social program should treat those who are economically equal the same, and those who are economically unequal differently.

For example, recipients who have liquid assets above the allowed limit or those who sell their residence while in a nursing home must apply the assets or proceeds from the sale toward the cost of nursing home care. On the other hand, the homes of recipients who still own property at the time of death will not be applied to the cost of their care unless the state has established an estate recovery program. Because in many cases the liquid assets of persons who must "spend down" to get Medicaid benefits are substantially less than the value of a home, allowing property to revert to heirs without subtracting the costs of care is inequitable.

## **VIRGINIA'S CURRENT STRATEGY FOR ESTATE RECOVERY**

While DMAS has, on occasion, recovered from the estates of deceased recipients, the agency does not have a formal recovery program. DMAS officials state that they have chosen not to adopt such a program because they believe the potential for significant recoveries is limited. DMAS has conducted a systematic analysis of the potential benefits of implementing such a program, but this effort did not include field verification of property ownership and Medicaid payment amounts for program recipients.

### **DMAS' Current Estate Recovery Policy Yields Little Savings**

Estate recovery in Virginia is not a proactive process. DMAS does not routinely track or collect data on recipients who own real property for the purpose of estate recovery. DMAS officials indicated that they consider recovering from the estates of deceased recipients only if they are notified that a recipient's estate is in probate. This strategy has not, however, helped to substantially defray the cost of providing nursing home care in Virginia.

*Current State Policy on Recovery.* DMAS currently relies on staff in the local social service offices to notify DMAS' fiscal division when there is a potential to recover from the estate of a deceased Medicaid recipient. However, there is no formal policy that requires the local offices to notify DMAS' central office when there is potential for recovery.

DMAS officials state that some local offices routinely notify DMAS' fiscal division when a recipient who owns property is terminated. For these cases, DMAS assesses the possibility of initiating recovery action. However, in interviews with eligibility workers in 14 local social services offices, JLARC staff found that the majority of these offices do not report to DMAS when a nursing home resident who owns property dies. Eligibility staff in only one of the 14 offices visited indicated that it routinely reports these cases. The others, citing DMAS' lack of policy on this issue, stated that they did not report potential recoveries.

*Estate Recovery Collections to Date.* DMAS staff point out that its policy requiring nursing home recipients to sell their property after six months on Medicaid



saves the State about \$3.6 million each year. However, partly due to the absence of a system for identifying available property, DMAS has recovered very little from the estates of Medicaid recipients who either are not required to or are unable to sell their property in six months. Since 1989, the agency has recovered \$45,189.

According to DMAS officials, one problem limiting the agency's ability to initiate effective recovery actions is a lack of resources. Without staff to track probated estates for persons who are deceased but still have property, the agency does not receive notification in sufficient time to initiate a recovery. Because the State does not have an opportunity to place a claim against the estate prior to probate, it is unable to realize any of the proceeds of the estate.

### **DMAS' Rationale for Lack of Recovery Program Not Supported**

DMAS officials reported that the agency has not taken a more proactive approach to estate recovery for two reasons. First, because the State has been able to impose eligibility requirements that limit the period of time during which a home is considered exempt, the number of people who own homes at the time of their death is minimal. Secondly, DMAS officials maintain that because State law prohibits the agency from placing liens on the property of Medicaid recipients, it would be difficult to track property to ensure that it is preserved for recovery.

*Limitations on Exempt Status of Home.* As noted previously, Virginia's status as a 209(b) state has allowed it to adopt requirements on exempt assets more stringent than those imposed by federal law. Specifically, in Virginia, a home is excluded as a countable resource only for the first six months of a recipient's stay in a nursing home. At the end of this period, there is an assumption that the individual will not return to the home. At this point, nursing home residents who remain institutionalized and who want to continue to receive Medicaid must sell their homes. If the home is sold, the recipient is terminated from Medicaid and the proceeds of the sale are then applied to the patient's care. If there is a spouse or dependent child in the home, the home will remain an exempt resource.

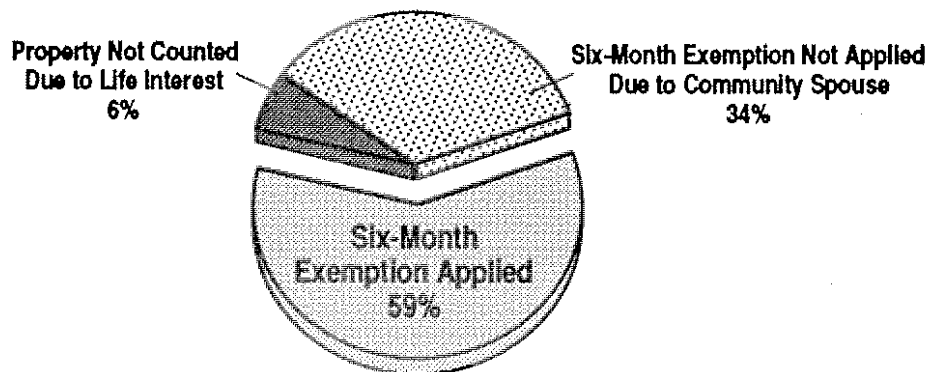
In order to ensure that the homes of recipients who remain in care after six months are sold, eligibility workers in the local social service offices are required to track these cases. At the end of six months, the eligibility worker notifies the recipient that the home must be put up for sale. If the eligibility worker determines that the recipient is not making a reasonable effort to sell, Medicaid payments will be terminated.

Because of this policy, DMAS officials maintain that the potential for recovery at the time of the recipient's death is greatly reduced in comparison to other states. Most states exempt the home as a countable resource indefinitely, thus at the time of the recipient's death, the home is likely to remain as a potential recoverable asset. DMAS officials claim that in Virginia, a recipient's home is likely to have already been sold and the profit applied to the recipient's care.

This does not appear to be supported by data on the number of people to whom the six-month exemption applied. JLARC staff analysis of 510 cases indicates that 22 percent of all persons who applied for Medicaid nursing home benefits in 1991 either owned a home or had life interest in the property. However, in 34 percent of these cases, DMAS' policy requiring a sale of the property after six months could not be applied because the applicant had a spouse (Figure 13). The total projected value of the property for these individuals was \$21 million. Appendix B describes how this estimate was made.

Figure 13

### Six-Month Exemptions for 1991 Nursing Home Applicants Who Owned Property



Source: JLARC staff analysis of Medicaid eligibility files for a sample of 510 persons who received nursing home benefits in FY 1991.

***Lack of Lien Authority.*** Another reason DMAS has not taken a more proactive approach to estate recoveries is the fact that it does not have the authority to place liens against recipients' homes. Although federal law permits states to place liens for the purpose of recovery of benefits paid on the Medicaid recipient's behalf, State law prohibits this practice in Virginia. DMAS officials contend that without lien authority it would be difficult to ensure that property is not sold or otherwise disposed of before DMAS can place a claim against it.

### **DMAS Estimates \$2 Million Can Be Recovered**

DMAS officials estimated that in 1990, approximately \$2 million could be collected if a recovery program were in place. However, this amount is not based on an analysis of the rate of property ownership among Medicaid nursing home residents, the value of that property, and the amount of benefits paid on behalf of these recipients.

According to DMAS officials, the estimate was derived based on the number of people who were residents of nursing homes and the probability that they may have owned property. This figure was used in conjunction with data on the average amount of benefits paid on behalf of nursing home residents. It did not, however, take into consideration the value of the property owned.

Moreover, in developing its estimate, DMAS considered only recipients who received less than six months of nursing home care. This was in accordance with their assumption that the property of nursing home residents who remained in care beyond six months would have already been sold. However, as will be discussed in the next section, this is not a valid assumption.

## **THE POTENTIAL BENEFITS OF ESTATE RECOVERY IN VIRGINIA**

In order to determine whether an estate recovery program could substantially defray the cost of nursing home care in Virginia, JLARC staff assessed whether DMAS' six-month limit means that very little property exists at the time a Medicaid recipient is terminated from the program. To do this, research was conducted to determine what percentage of recipients owned a home in 1990 after their eligibility for Medicaid had ended.

After determining the amount of property that existed, further analysis was conducted to determine how much of the benefits paid on behalf of the recipients who owned property could have been defrayed through estate recovery. (A detailed discussion of the methodology used to conduct this analysis is included in Appendix B of this report).

The results of this research show that, despite the limit placed on the length of time a home may remain exempt, a significant portion of nursing home residents retain possession of their homes when they die. Moreover, additional analysis indicates that the value of the property is such that the majority of benefits paid on behalf of these individuals could be defrayed if the State had a proactive recovery program.

### **Property Is Available When Recipients Are Terminated From Medicaid**

JLARC's review of the property records of a random sample of 447 recipients who were terminated from a nursing home and the Medicaid program in 1990 shows that 16 percent of these recipients had real property at the time they were terminated from the program. This contradicts DMAS' assumption that property for these former recipients will have already been applied to the individual's cost of care. Rather, it appears that a significant amount of property exists that could ultimately be recovered.

It is important to note, however, that this analysis included all people who were terminated from Medicaid, regardless of their length of stay in the nursing home. Thus, it appears that in some cases, DMAS may not have had an opportunity to enforce its six-

month exemption. However, in most cases, the recipients had been in a nursing home for more than six months at the time they were terminated. Regardless of the length of stay, the fact remains that without a recovery program, the proceeds of the sale of these homes are lost and cannot be used to offset the cost of the care provided to these recipients.

*Amount of Real Estate Available at Program Termination.* Of all recipients terminated from care in 1990, 16 percent remained in possession of their homes. As shown in Table 3, the average property value for these recipients is \$47,706. Statewide, recipients who were terminated in 1990 owned \$41.3 million worth of property. This is a conservative estimate because JLARC staff could not identify all property owned by these recipients.

*Reasons Property May Remain at Program Termination.* Interviews with eligibility workers in the local social service offices seem to indicate that DMAS strictly enforces the requirement that the recipient's home be sold after six months of nursing home care.

However, it appears that for many recipients the home has not been sold at the time they are terminated from the program. This happens for a number of reasons.

First, many of the recipients in our sample had been in a nursing home for less than six months. Accordingly, because DMAS exempts the home for six months, it would not have had an opportunity to force a sale for these cases. Forty-one percent of the people in the JLARC sample who owned property were in this category (Figure 14). The remaining 59 percent, however, were terminated after having received over six months of nursing home care.

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Table 3

**Projected Number and Value of Real Estate  
Owned by Medicaid Recipients Terminated  
from a Nursing Home in 1990**

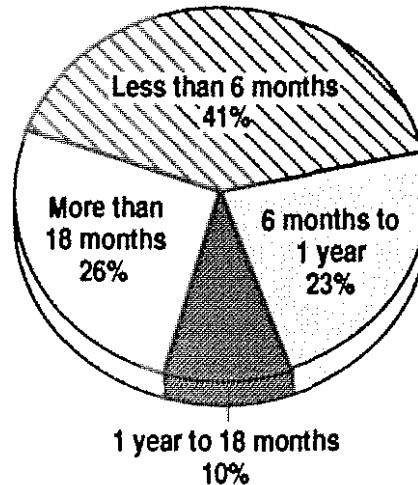
Recipients Terminated from Nursing Homes	5,412
Projected Home Ownership (Percent)	16
Projected Home Ownership (Number)	812
Average Value of Real Property	\$47,706
Projected Total Value of Property	\$41.3 million

Notes: The sampling error for the proportion of persons who owned property is three percent. The average value of the property represents a stratified mean. The projected total value of property was calculated at a 95 percent confidence level. The range of this interval has an upper bound of \$57,704,259 and a lower bound of \$27,645,941. This means that there is a 95 percent probability that the actual population mean is within the interval. (A detailed discussion of the methodology used to calculate these statistics is included in Appendix B).

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Figure 14

### Length of Stay for Sample of Nursing Home Residents Who Owned Property



Source: JLARC staff analysis of automated recipient eligibility files and local property records.

In these cases, it is possible that DMAS had initiated action to force the sale of the home, but the recipient had not been able to complete the transfer before being terminated from the nursing home. According to DMAS policy, as long as the recipient is making a bona fide effort to sell, Medicaid assistance will continue. However, more than one-quarter of the recipients in the JLARC sample who owned property had been in a nursing home for more than eighteen months. For these cases, it is not clear why DMAS had not forced the sale of the home.

A second reason relates to the identification of property. Because local social service offices are not required to verify property ownership, it is possible that the office was unaware of the existence of some of this property. When this occurs, under current policy, it is impossible for the eligibility worker to initiate action to require the home to be sold. These properties will inevitably revert to the recipient's heirs at the time of death.

A final reason that property may have existed at the time the recipient was terminated was if there was a spouse or dependent child living in the home. A home will remain exempt as long as a spouse or child resides in it.

Regardless of the reason that the property remained at the time the recipient was terminated, the State still has the ability to recover benefits paid. There is no limit on the amount of time that a recipient must be in a nursing home before the State can recover. Even in instances in which a spouse remains in the home, recovery is possible because federal law permits recoveries to be made when the spouse at home dies.

### Use of Property Could Recover Some of the Cost of Nursing Home Care

The value of property owned by Medicaid recipients at the time of discharge, in and of itself, is not indicative of the amount of money that could be recovered through estate recovery. The property value must be compared to the amount of benefits that have been paid on behalf of the recipient. The lesser of the two represents the amount of money that could be recouped.

JLARC staff analysis of both property values and benefits paid indicates that the State could recover as much as two-thirds of the total cost of nursing home care for recipients who were terminated in 1990. In total, approximately \$9.7 million could be recovered from former recipients if the State had a proactive recovery program. Appendix B describes the methods used to estimate the total recovery amount.

It is important to note that the total of \$9.7 million would not be immediately available for recovery. In some cases, even though the nursing home residents die owning property, their spouse may remain in the home for a number of years, thus preventing the foreclosing of the lien. This time period would likely be greater if the nursing home resident had dependent children still living in the home.

Also, even when the property could be sold immediately to satisfy the lien, the actual time associated with this process would vary based on the condition of the house and the nature of the real estate market. DMAS staff estimate that approximately \$2.6 million could be collected on an annual basis.

Further, there are a number of factors that will affect how much of this amount will actually offset the State's expense in providing nursing home care to Medicaid recipients. First, because Medicaid is a joint federal-State program, half of the benefits recovered must be returned to the federal government.

In addition, the amount that can be recovered may be affected by whether or not the recipient was still making mortgage payments. Although JLARC staff were not able to determine what portion of the recipients in the study sample had outstanding debt, a General Accounting Office (GAO) study has found that only seven percent of property owners who received Medicaid were still making mortgage payments.

Even with these caveats, it appears that by recovering from the estates of deceased Medicaid recipients or their spouses, as much as two-thirds of the cost of providing nursing home care to Medicaid recipients who own homes could be defrayed.

***Recommendation (8).*** In order to defray the cost of nursing home care, the General Assembly may wish to consider requiring the Department of Medical Assistance Services to implement a proactive recovery program.

## REQUIREMENTS FOR ESTATE RECOVERY IN VIRGINIA

If DMAS were to implement a more proactive estate recovery process, a number of both statutory and programmatic changes would need to be made. In examining the modifications that would be required, it is useful to review the efforts of states that have implemented effective recovery programs. The structure of estate recovery programs in the 22 states that have them vary greatly. However, according to research conducted by the GAO and the federal Department of Health and Human Services' (HHS) Inspector General, the programs in the states with the most well developed recovery efforts have a number of features in common. Based on the results of these studies and others, this section outlines a number of key legal and policy issues that will need to be addressed if estate recovery is to be successful in Virginia.

### Statutory Changes Would Enhance Recovery Potential

According to the GAO and HHS, strong state legislation on various aspects of estate recovery are present in the states that have implemented successful changes. While statutory change is not absolutely necessary in order to implement a recovery program in Virginia, certain legislative changes could greatly strengthen the ability of the State to make recoveries.

*Statutory Provisions Authorizing Recoveries.* Literature on estate recovery repeatedly refers to Oregon as the state with the most well developed and cost-effective recovery program. In its analysis of this issue, GAO noted that one element of Oregon's program that makes it so successful is that it has enacted laws specifically authorizing recovery and establishing the conditions under which recoveries can be made. By authorizing recoveries from the estates of surviving spouses, for example, Oregon ensures that jointly held property is not lost to the state when the recipient dies. Without a policy that allows recovery from the spouse's estate, the state loses its ability to recover benefits paid for the recipient.

**Recommendation (9).** The General Assembly may wish to consider enacting legislation that would authorize the recovery of benefits paid on behalf of institutionalized Medicaid recipients. Such a law should include provisions that allow recoveries from the estates of the recipients' spouses.

*Statutory Provisions Authorizing Liens.* As previously noted, federal legislation provides states with the authority to place liens on the property of institutionalized Medicaid recipients. However, because the legislation also places limits on the circumstances under which liens are permitted, many states do not utilize their lien authority. It appears, however, that lien authority could improve the State's ability to ensure that the proceeds of the sale of a home are applied to the recipient's care.

The most obvious advantage in the use of lien authority is that it enhances the state's ability to preserve assets. By placing a lien on property at the time the recipient

enters a nursing home, the state is ensured that the home will not be sold or transferred unless the state's interest is first satisfied. Although states are prevented from foreclosing on a lien if there is a spouse or dependent child in the home, the lien will effectively hold the state's interest in the property until the home is sold. At this time, the state's claim will automatically be considered along with other claimants.

In 1991, three of eleven states that utilized their lien authority — Connecticut, Maryland, and Massachusetts — were all ranked by the HHS Inspector General as being among the top states in terms of overall effectiveness in recovery programs. Many other states permit recoveries from Medicaid recipients; however, because of the perceived federal limitations on placing liens, they have not utilized this authority.

Under current State law, DMAS is prevented from placing liens on nursing home residents receiving Medicaid assistance. Specifically, section 63.1-133.1 of the *Code of Virginia* states:

No lien or other interest in favor of the Commonwealth or any of its political subdivisions shall be claimed against, levied or attached to the real or personal property of any applicant for or recipient of public welfare assistance and services as a condition of eligibility therefor or to recover such aid following the death of such applicant or recipient.

By changing this law to permit recoveries from Medicaid recipients, the State's chances of preventing property from being sold or otherwise disposed of before its claim is satisfied is greatly improved.

**Recommendation (10).** In order to enhance Virginia's ability to recover benefits paid on behalf of institutionalized Medicaid recipients, the General Assembly may wish to consider revising Section 63.1-133.1 of the *Code of Virginia* to allow liens to be attached to the real property of Medicaid recipients.

### **Programmatic Changes Are Needed for Estate Recovery**

In order to implement a more proactive recovery program in Virginia, certain programmatic changes would be required that would allow DMAS to better identify, track, and recover assets. Because DMAS has been strict in its enforcement of the six-month exemption of property, the changes required to identify and track property are minimal.

The most significant changes that will be required are in the actual recovery process. In order to implement these changes, it is likely that DMAS will require additional resources. Any decision about the structure of a recovery program should incorporate the findings of a detailed analysis of resource requirements.



Identifying Property. The first step in implementing an effective recovery program is identifying the amount of property owned by Medicaid nursing home residents. The local social service offices will need to continue to collect information during the application process on the amount of property owned by the applicant. However, in order to ensure that property does not go unreported, property ownership should then be verified by the Clerks of Court as recommended in Chapter II. This would control for both underreporting of property and for intentional omissions of property ownership.

Once the information reported on the application has been verified, the data would be sent to a central recovery unit in DMAS. According to both GAO and HHS, the existence of such a unit is very important in facilitating recoveries. The state of Oregon, for example, has established an Estate Administration Unit that is made up of staff proficient in legal, property, and probate transactions. This unit plays a key role in tracking, preserving, and recovering assets.

Tracking Property. Tracking property to make sure that it is not sold, given away, or otherwise disposed of, is another important element of a successful recovery program. Again, the local social service offices play an important role in this aspect of recovery. The eligibility workers would be responsible for notifying the central recovery unit if there is a change in the status of a recipient's property ownership. This information would be gained during the annual eligibility redetermination process. If the property has been sold or given away, the local social service office would notify the Estate Administration Unit which would initiate appropriate action.

Recovering Property. The actual recovery is the most important aspect of the process and the one that would require the most significant programmatic change. The process would vary depending on whether or not the State attempts to recover from both the estates of recipients and their surviving spouses. It would also vary depending on whether the State enacts laws that will allow the placement of liens.

One of the most important elements of the recovery process would be the immediate notification by the local social service office to DMAS' central recovery unit of the death of the nursing home resident. While local social service offices are currently notified by the nursing homes when a Medicaid recipient dies, as noted above, the offices are not required to notify DMAS of the death. Prompt notification would have to be mandatory in a proactive recovery process. This is particularly important if there is no lien on the property that would guarantee that the State's claim on the property would be satisfied.

In Oregon, the local offices are required to submit a report to the State's central recovery unit within 5 days of the recipient's death. The report contains information on the recipient's assets and on surviving family members. If the recipient had property at the time of death, and had no surviving spouse or dependents, the central recovery unit would begin action to recover benefits paid. If the recipient had a surviving spouse, the central recovery unit would fill out a data card on the spouse so that future recovery could be made from the spouse's estate.

With regard to recovery from former recipients or surviving spouses the State would need to develop a system to identify potential recoveries. In Oregon, the central recovery unit reviews monthly lists of probate court actions sent by local offices. If a former recipient or a former recipient's spouse is identified, the unit calculates the amount of benefits paid on the recipient's behalf and files a claim against the individual's estate (Figure 15).

***Resources Required to Implement a Recovery Program.*** The benefits that are achieved from implementing estate recovery programs must be viewed in conjunction with the actual cost of the recovery process. In the states that have implemented recovery programs, recovery ratios vary. In Oregon, for example, according to the HHS Inspector General's report, for every \$13 that is recovered, only one dollar is spent. In total, Oregon spent \$376,000 to operate its recovery program in 1986. The average recovery ratio for the 22 states that have recovery programs is approximately \$14 recovered for every one dollar that is spent. The ratios range from \$1.73 in Rhode Island to \$51.36 in Massachusetts.

However, as pointed out in the Inspector General's report, the recovery ratios can be somewhat misleading:

For example, Massachusetts, with a recovery ratio four times Oregon's, recovers less than one-fourth as much as Oregon overall per elderly Medicaid recipient. Presumably, Massachusetts could add staff, recover much more, and still maintain a satisfactory recovery ratio. The bottom line, therefore is not the recovery ratio, but the total amount cost-effectively returned to Medicaid to meet the needs of other recipients.

In order to implement a recovery process such as that outlined above, DMAS will likely require additional central office staff and resources. It is important to realize, however, that because a portion of the recovery is returned to the federal government, it will also share in the cost of the program. While it was beyond the scope of this study to conduct an intensive staffing analysis to identify exactly how many full-time equivalent positions would be required, it is necessary to consider this in determining whether an estate recovery program will be cost beneficial.

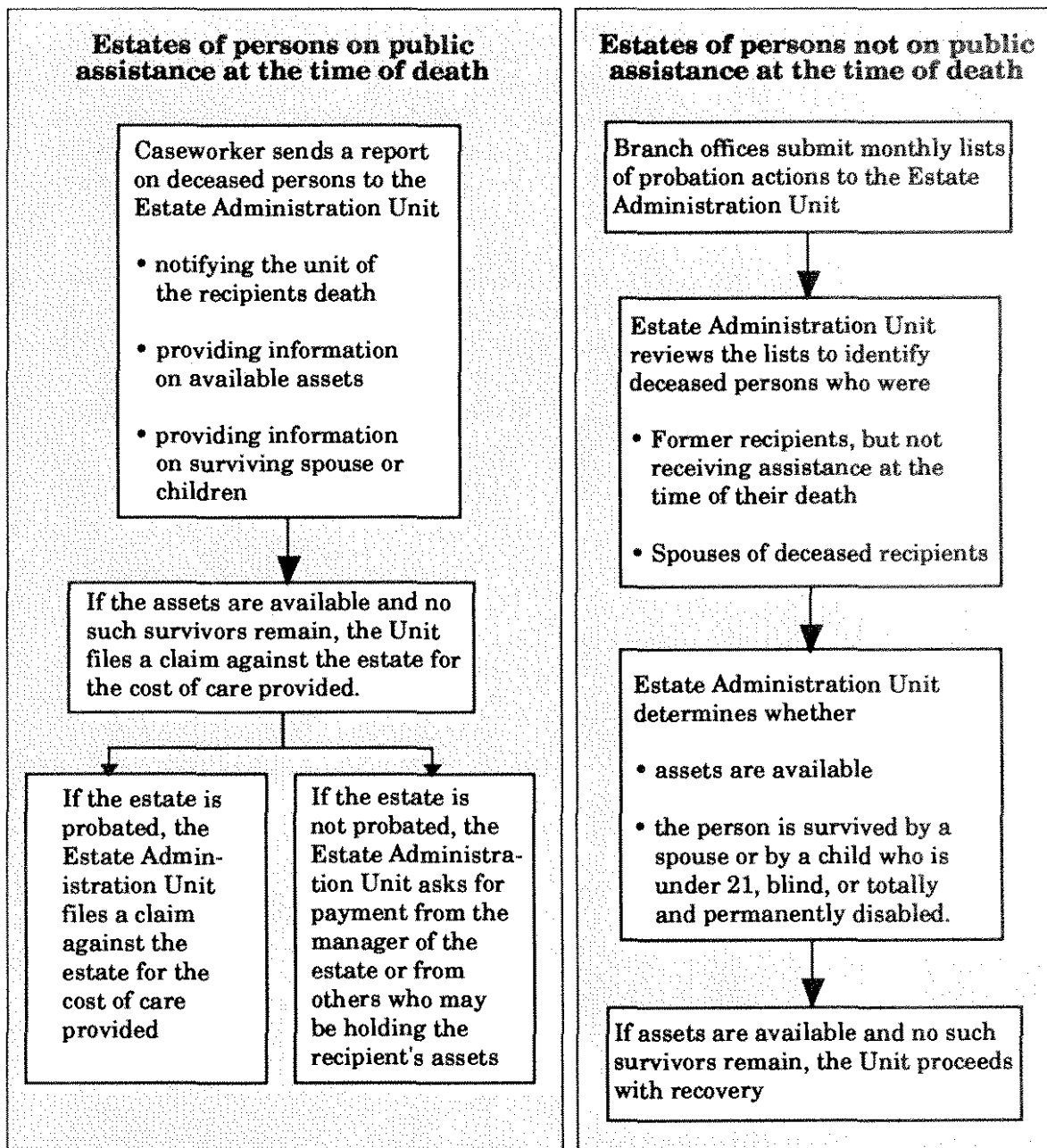
***Recommendation (11).*** The General Assembly may wish to direct the Department of Medical Assistance Services to conduct an analysis of the amount of resources that would be required to implement a proactive recovery program.

## CONCLUSIONS

Estate recovery has proven to be an effective means of defraying the cost of nursing home care in the states that have implemented such programs. The lack of a

Figure 15

## Oregon's Estate Recovery Process



Source: U.S. General Accounting Office Report, *Medicaid: Recoveries from Nursing Home Residents' Estates Could Offset Program Costs* (GAO/HRD-89-56)

proactive recovery program has prevented Virginia from achieving the same benefits as in other states. The results of JLARC staff's analysis show that 16 percent of the Medicaid recipients terminated from nursing homes in Virginia own property. It appears that as much as two-thirds of the cost of providing nursing home care to these people could be recouped through estate recovery.

In order to realize the maximum benefits of estate recovery, a number of legislative and programmatic changes will need to be made. Legislation authorizing estate recoveries from both Medicaid recipients and their surviving spouses would solidify the State's claim against their estates. In addition, statutory provisions for placing liens on the property of Medicaid recipients would enhance the State's ability to collect from the sale of the property.

An examination of the administration of estate recovery programs in other states suggests the need for the creation of a centralized estate recovery unit in DMAS. Prior to the establishment of a more proactive recovery program, DMAS will need to conduct an analysis of the cost of creating such a unit. It appears, however, that the magnitude of potential recoveries in Virginia makes the cost of implementing an estate recovery program worthwhile.

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## Appendixes

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## Appendix A

### Senate Joint Resolution No. 91

Requesting the Commission on Health Care for All Virginians to study the issue of property transfer for purposes of Medicaid eligibility.

Agreed to by the Senate, March 5, 1992

Agreed to by the House of Delegates, March 3, 1992

WHEREAS, health care spending continues to increase at a rapid rate; and

WHEREAS, the cost of Medicaid for the elderly is increasing at a rapid rate due to the aging of the general population; and

WHEREAS, the Medicaid budget is projected to grow by \$743 million over the previous biennium; and

WHEREAS, many persons give away assets or otherwise dispose of resources they could use to purchase medical care, especially nursing home care, in order to become Medicaid-eligible; and

WHEREAS, the federal Medicaid eligibility rules regarding transfer of assets have been made more lenient in recent years; and

WHEREAS, it is common practice for persons anticipating the need for medical care for themselves or their relatives to consult attorneys and financial planners familiar with Medicaid law and regulations for advice on ways to circumvent the Medicaid rules so as to transfer assets to establish Medicaid eligibility; and

WHEREAS, the Joint Legislative Audit and Review Commission is examining Medicaid financing of long-term care including the issue of asset transfer and asset recovery, as directed by Senate Joint Resolution No. 180 passed by the 1991 General Assembly; and

WHEREAS, the resources of the Commonwealth should be used to help those most in need who do not have resources with which to purchase health care; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Commission on Health Care for All Virginians be requested to study the current practice of persons transferring or giving away assets without compensation so that they can become eligible for Medicaid, and to recommend to the General Assembly options available to limit the financial impact of such practices on the taxpayers of Virginia.

The Joint Legislative Audit and Review Commission shall, upon request of the Commission, discuss its study plan and report its findings and recommendations to the Commission prior to the 1993 Session of the General Assembly.

The Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1993 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for processing legislative documents.

## Appendix B

### Sampling Strategy for Asset Transfer and Estate Recovery

This appendix explains the sampling strategies and estimation techniques that were used to calculate the statewide projections for the study of asset transfers and estate recovery in Virginia. In addition, a description of each step that was used to determine the total amount of benefits which could be recovered from each sample member for the estate recovery analysis is provided.

#### Stratified Sampling Technique Used

There were three primary goals of the analysis of asset transfers and estate recovery which guided the approach used to select the study samples: (1) to identify the proportion of new Medicaid nursing home enrollees who transferred assets prior to applying for Medicaid nursing home benefits; (2) determine the number of people who failed to report their ownership interest in real property during the application process; and (3) identify the amount of property that was owned by former recipients of Medicaid nursing home benefits.

The Department of Medical Assistance Services maintains automated files on each recipient of nursing home care but these databases do not contain specific information on the applicants' assets. The eligibility files which contain much of the information on recipients' assets are maintained by caseworkers in 124 local social service offices. Information on the recipients' property is maintained in "land books" located in the Clerks of Court offices or local finance departments.

*Geographic Distinctions in Sampling.* Because of this, JLARC staff had to develop databases with this type of information to project findings for the universe of nursing home recipients. To do this, the State was separated into 10 different strata based on the geographic region and the size of the Medicaid caseloads. Geographic region was used as one stratifying variable to account for the possibility that property ownership and asset transfer practices would vary according to particular locations in the State.

Specifically, the State was divided into five regions. The offices in three of the regions — Western, Piedmont, and Eastern Virginia — served mostly rural localities. In many of these localities, a number of the Medicaid applicants live below the poverty level but are believed to possess significant amounts of property (e.g. farms). To ensure that these individuals were adequately represented in the sample, the regional distinctions were made in the sampling process.

*Caseload Size Distinctions in Sampling.* Two measures of caseload size were used. Local offices that processed fewer than 1500 total Medicaid cases per year were considered small. All other offices were categorized as large. Caseload size was used as



a stratifying variable to capture differences in procedures used by eligibility workers to process cases which are related to workload. For example, in larger offices, the caseload work can be so pressing that it prevents the workers from checking to see if all applicants owned property. Over time, this could result in a higher proportion of applicants who shelter resources from the program by simply refusing to report it.

***A Total of 14 Offices Sampled.*** Once each of the 124 local offices were organized into 10 strata, the study team randomly selected 11 offices to visit. In addition, to ensure representation of local welfare offices with large caseloads, three primarily large urban offices were added to the sample. Table B.1 provides a list of the offices that were included in the study.

***Recipients Randomly Selected.*** Within each of the 14 offices, a sample of recipients was randomly selected. In some offices, the number of new nursing home applicants (for asset transfer analysis) or persons discharged from the nursing homes (for estate recovery analysis) was sufficiently small such that the universe of recipients could be included in the sample. In large offices, staff sampled a proportion of the universe which varied depending on the total number of cases in the offices.

Different selection criteria were used for the samples selected to address the asset transfer and estate recovery issues. For asset transfer, the focus was on program applicants who were seeking admission to a nursing home for the first time. To identify this group, the following steps were taken:

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Table B-1

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### **Local Social Service Offices Visited By JLARC Staff**

<u>Locality</u>	<u>Stratum</u>
City of Hampton	1
City of Richmond	1
Hanover County	2
King and Queen County	2
Fairfax County	3
City of Fredericksburg	3
Warren County	4
Washington County	5
Bland County	6
Amherst County	7
Buckingham County	8
Brunswick County	9
City of Chesapeake	9
Sussex County	10

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- First, using DMAS' automated recipient files, all persons who applied for nursing home benefits for the first time through one of the 14 local offices were identified in 1991.
- Second, if the total number of applicants in any office was less than 50, all of those cases were included in the sample.
- Third, if the total number of cases exceeded 50, a proportion of these cases were selected based on the total number.

For the estate recovery analysis, the objective was to identify persons who were discharged from both a nursing home and the Medicaid program in 1990 and had no additional periods of eligibility as of September 1991. To select the sample, DMAS' automated recipient file was used to identify all persons who meet the following criteria:

- (1) established eligibility for nursing home benefits through one of the 14 local social service offices included in the study;
- (2) were in a nursing home receiving Medicaid support in 1990;
- (3) were discharged from a nursing home in 1990;
- (4) did not have a subsequent period of Medicaid eligibility as of September 1991.

The sample sizes for both the asset transfer and estate recovery analysis are reported in Table B.2. As shown the sample size for estate recovery was 510 cases. An additional 452 cases were sampled for the analysis of estate recovery.

*Assumption Made for Statewide Projections.* The purpose of random sampling is to make inferences about the underlying population through a single parameter called a point estimator. The assumption being made in this study is that the statistics calculated as point estimators (e.g. average value of assets transferred) are good predictors of the population parameters. This assumption is based on the view that the random stratified sample of Medicaid recipients included in this study is representative of the universe of program beneficiaries.

*Use of Sample Proportions and Stratified Means.* Each Statewide projection in this study was derived from the use of point estimators represented by stratified sample proportions and stratified means. Stratified sample proportions (e.g. the percent of Medicaid applicants that own property) were used to estimate population proportions for the entire program. For example, it was determined that 37 percent of the new Medicaid enrollees were above the program's resource limit at the time of program application. This was treated as an estimated population proportion for all new nursing home applicants. Sampling errors for the sample proportions were calculated using a 95 percent level of confidence.

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**Table B-2**

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**Cases Sampled in Each Strata  
For Asset Transfer and Estate Recovery Analyses**

<u>Stratum</u>	<u>Total Cases Asset Transfer Analysis</u>	<u>Sample Cases Asset Transfer Analysis</u>	<u>Total Cases Estate Recovery Analysis</u>	<u>Sample Cases Estate Recovery Analysis</u>
1	1,210	107	969	104
2	406	65	340	46
3	1,246	89	936	71
4	325	32	288	25
5	664	50	453	39
6	148	19	99	12
7	1,491	31	1,000	24
8	433	21	243	12
9	1,136	79	1,031	92
10	<u>76</u>	<u>17</u>	<u>53</u>	<u>22</u>
<b>Totals</b>	<b>7,135</b>	<b>510</b>	<b>5,412</b>	<b>447</b>

Notes: There were some recipients that met the criteria for either the asset transfer or estate recovery analysis but could not be included in the analysis because the local office that processed their Medicaid application could not be determined. Three cases were dropped from the analysis of estate recovery because data on their length of stay in nursing homes could not be determined and therefore could not be used. Two additional cases were excluded because the recipients only had life interest in the property.

Source: JLARC staff analysis.

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Stratified means were used to estimate the value of the resources either held or transferred by the total Medicaid population. For example, the stratified mean for the 33 percent of the sample with excess resource limits was \$30,238. This was treated as a point estimate of the average resources for all new enrollees with assets above the resource limit. Confidence intervals (at the 95 percent level of confidence) were eventually calculated for the stratified means.

***Sampling Errors for Sample Proportion.*** When working with sample proportions, a key issue is how precise the statistic is as an estimate of the population proportion. Sampling errors define the level of precision around the sample proportion and they are based on the size of the sample from which the proportion is calculated. The lower the sampling error, the closer is the sample proportion to the true population parameter. The formula used to calculate these sampling errors at a 95 percent level of confidence is shown below. Notice that as "n" gets larger, the value for the sampling errors will decrease.

$$Ep = t \sqrt{\frac{p(1-p)}{n}}$$

where:

EP = Sampling error of proportion.

t = t statistic corresponding to the level of confidence

n = number of observations in sample

p = proportion of sample in category (e.g. percent with property.)

Table B-3 reports the sampling errors for each proportion that was used as a point estimate for the population in the study of both asset transfers and estate recovery.

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Table B-3

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**Sample Proportions And Associated Sampling Errors  
For Point Estimates Used In The Study Of  
Asset Transfers and Estate Recovery**

<u>Variable Definition</u>	<u>Sample Proportion</u>	<u>Sampling Error</u>
Proportion of Medicaid applicants with resources over the program's limits	37%	4%
Proportion of Medicaid applicants who transferred resources	27%	4%
Proportion of Medicaid applicants who used loopholes to transfer assets	8%	2%
Proportion of Medicaid applicants who owned property with a spouse that was not covered by the State's six-month exemption	7%	2%
Proportion of former Medicaid nursing home recipients who owned property at the time they were discharged from the nursing home	16%	3%

Source: JLARC staff analysis of data collected from the eligibility files and property records of Medicaid recipients.

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Use of Stratified Means. The stratified sampling approach used in this study allowed the team to account for differences in property ownership and the incidence of underreporting of assets among recipients which was related to the location and size of the eligibility office. The formula that was used to calculate each of the stratified means is provided below.

$$\overline{y}_w = \sum w_h \overline{Y}_h$$

where:

- $\overline{Y}_w$  = Stratified mean
- $\overline{Y}_h$  = Average for each sample stratum
- $W_h$  = Stratum sample weight defined as proportion of stratum cases

The actual population estimates reported in this study were derived from multiplying the stratified means times the proportion of cases in the population estimated to fall into a particular category. For example, to calculate the total amount of resources transferred through the use of loopholes, the following steps were conducted:

- First, the proportion of new Medicaid nursing home enrollees in the sample who transferred assets using loopholes were identified (seven percent).
- Second, this proportion was multiplied by the total number of new Medicaid nursing home enrollees for the State (7,135).
- Third, this product was then multiplied by the stratified mean to generate a statewide estimate of resources transferred through the use of loopholes.

Confidence Interval for Stratified Means. The final step in the methodology for calculating Statewide estimates was the construction of confidence intervals. The confidence interval is an interval of numbers within which the value of the estimated parameter is believed to lie.

For all estimates in this study, a 95 percent level of confidence was used. This means that the probability that the confidence intervals contain the true population parameter is 95 percent. As shown, these confidence intervals were calculated by multiplying the t statistic representing a 95 percent level of confidence by the square root of the variance for the weighted means. The resulting estimate was then multiplied by the sample proportions to determine the upper and lower bounds of the confidence interval. The sampling errors and confidence intervals for this analysis are shown in Table B-4.

**Table B-4**

**Sample Proportions and Associated  
Sampling Errors for Point Estimates Used in the  
Study of Asset Transfers and Estate Recovery**

<u>Estimate</u>	<u>Stratified Proportion</u>	<u>Sampling Error</u>	<u>Stratified Mean</u>	<u>Sampling Error</u>	<u>Upper Bound</u>	<u>Lower Bound</u>
Proportion of Medicaid Applicants With Over The Program's Limits	37%	±4%	\$30,238	± \$4,054	\$100,319,635	\$61,650,582
Proportion of Medicaid Applicants Who Transferred Resources	27%	±4%	\$22,747	± \$2,282	\$ 55,358,811	\$33,584,515
Proportion of Medicaid Applicants Who Used Loopholes To Transfer Assets	8%	±2%	\$25,265	± \$2,331	\$ 19,689,930	\$ 9,818,227
Proportion of Medicaid Recipients Discharged in 1990 Who Owned With A Spouse	6%	±2%	\$50,441	± \$4,744	\$ 31,500,090	\$19,562,913
Proportion of Former Medicaid Nursing Home Recipients With Property That Can Be Used To Defray The Cost of Nursing Home Care	16%	±3%	\$11,269	± \$1,377	\$ 13,004,201	\$ 6,959,891

Notes: The sampling errors reported in this table were used to calculate the upper and lower bounds of the confidence intervals for each estimate. For example, 27 percent of Medicaid applicants in the sample transferred property. The sampling error for this proportion was 4 percent and the error for the stratified mean was \$2,282. Thus, the upper bound of the confidence interval for the total amount of resources transferred was determined by multiplying 31 percent (27% + 4%) of the total number of Medicaid applicants in FY 1991 times the stratified mean of \$25,029 (\$22,747 + 2282).

Source: JLARC staff analysis of Medicaid recipients' eligibility files and property records.

$$\overline{y_s} = \sqrt{\sum p_i^2 \frac{(SD)^2}{n}}$$

where:

- $\overline{Y_s}$  = confidence interval for stratified mean.
- $t$  = t statistic corresponding to level of confidence.
- $P_i$  = number in stratum as a proportion of population total
- SD = variance for stratified mean
- $n$  = number in stratum

## METHODOLOGY FOR ESTATE RECOVERY

This section of the appendix describes the methodology that was used to estimate the amount of resources that could be recovered from Medicaid nursing home recipients when they are terminated from the program. The results of this analysis were used to determine whether an estate recovery program could serve as a means of defraying the cost of nursing home care in Virginia. In order to conduct this analysis, JLARC staff conducted the following research activities:

1. Identified the extent to which a random sample of 452 Medicaid recipients who were discharged from nursing home care in 1990, owned property.
2. Determined the amount of benefits paid on behalf of the recipients in the sample.
3. Calculated the amount of benefits that could have been defrayed through estate recovery by taking the lesser of the value of the property owned or the amount of benefits paid on each recipient's behalf.
4. Projected recoveries to the universe of recipients discharged from care in 1990.

### Identifying Property Ownership

To determine whether or not the recipients in the sample owned property, JLARC staff examined property records in the locality in which the recipient applied for Medicaid. (This is also the locality in which the individual lived at the time of application.) These records were typically maintained in "land books" in the offices of the Commissioners of Revenue or Clerks of the Court.

For each sample member, a review of the "land books" was conducted to determine whether the individual owned property during the three years prior to

discharge from Medicaid. If the "land book" showed that the recipient owned property, the assessed value of the property was recorded. In Virginia the assessed value is supposed to represent the fair market value of the property, so no further adjustments were made to the amount.

In cases in which the "land books" indicated that the property was jointly owned by more than one individual, JLARC staff divided the value of the property by the total number of owners. This was done to ensure that only the recipient's share of the property was counted as recoverable. However, if the co-owner was the recipient's spouse, the full value of the property was included. This is based on the assumption that the State could recover from the spouse's estate.

In calculating the total value of the property owned by the Medicaid recipients in our sample, the value from the "land books" was multiplied 80 percent. This was done under the assumption that a portion of the estate would be used to pay such estate expenses as real estate agent and attorney fees and would therefore be unavailable for recovery.

Finally, if the property record indicated that the recipient had only a life interest in the property, the property was excluded from our analysis. Because the review of property records was limited to the locality in which the individual applied for program benefits, it could possibly understate the amount of property owned. If the recipient owned property in another locality or out of state, it would not have been included in this analysis.

### **Determining Amount of Benefits Paid**

To determine the amount of benefits paid on behalf of the recipient, an automated file from DMAS' claims database was used. This file included the amount of nursing home claims paid on behalf of the recipients in our sample.

For three recipients in the sample, data were not available on the amount of benefits paid. For these people, JLARC staff used the average amount of benefits paid for people with similar lengths of stays in nursing homes. In three additional cases, data were not available on either the amount of benefits paid or the recipients' length of stay in the nursing home. These cases were dropped from the analysis.

Federal regulations are unclear as to whether states can recover the total amount of benefits paid while the recipient was in a nursing home (including such things as outpatient hospital fees, physical therapy, dental, etc.) or whether recovery is limited to only nursing home payments. So as not to overestimate recovery potential, only the amount of nursing home payments actually paid was used as the basis for recovery.



### **Calculating Potential Recovery**

In order to calculate the potential recovery for each recipient in the sample, JLARC staff used the lesser of the value of the property or the amount of benefits paid. For example, if the amount of benefits paid (less 20 percent for real estate and attorney fees) was \$15,000 and the value of the property owned was \$45,000, \$15,000 was used as the amount of benefits that could be recovered. To project these figures Statewide, the previously discussed estimation techniques were used.

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