Assessing Asset Transfer for Medicaid Eligibility in New York State

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About the Research

The purpose of this research was to assist the New York State Department of Health with examining long-term care (LTC) issues, under a grant from the New York State Health Foundation (NYSHealth). The New York State Department of Health asked the Rockefeller Institute of Government's Health Policy Research Center (HPRC) to learn more about Medicaid applicants and enrollees who require long-term care services. The Department of Health was interested in asset transfer rates among elderly who apply for Medicaid coverage for nursing facility services, the rates of Medicaid eligibility denials for this population, reasons for denial, and determining whether and how individuals spend down or transfer assets before qualifying for Medicaid-funded nursing facility services.[1]

This report explores ways to quantify asset transfers using data from the Department of Health and the state's Welfare Management System (WMS). It examines available New York State asset transfer denial information, as well as how or whether other states are tracking asset transfers among the elderly. It also provides information on the average spend-down over a 10-year period of those who were denied Medicaid nursing facility services because of asset transfers. This report was prepared by reviewing literature on long-term care asset transfer and Medicaid spend-down, analyzing DOH data and WMS Medicaid asset transfer denial information, and interviewing officials from a sample of other states.

About the Rockefeller Institute and Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York. The New York State Health Policy Research Center, a program of the Rockefeller Institute, provides relevant, nonpartisan research and analyses of state health policy issues for New York State and national policymakers. With funding support from the New York State Health Foundation and other foundations, HPRC uses its in-house staff of health policy experts, as well as national experts, to build on the Rockefeller Institute's strength in analyzing the role of state and local governments in financing, administering, and regulating state health care systems.

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The primary author is HPRC Research Scientist Ajita P. De. Suggestions on data sources, data extraction, protection, and access procedures were provided by DOH staff Wendy Butz; Adriana Takada and her team; Dennis DiMuria and his team; and Patricia Buttino, Peter Gallagher, William Armstrong, Lynn Couey, Karen Ambros and their team. Michael Brown, also of DOH, provided insight on the department's Medicaid Automated Budgeting and Eligibility Logic (MABEL) system. Medicaid asset transfer denial information for

[1] "Asset transfer" commonly refers to a practice where elderly people transfer assets to obtain Medicaid eligibility for their health care needs. "Elderly" is defined as people 65 years and older. Individuals who fail to qualify for Medicaid due to excess income often use private finances for health care expenses in order to meet Medicaid eligibility requirements. This is commonly known as "spend-down."

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Executive Summary

Background

Medicaid, a program funded jointly by the federal and state (and in some states by county) governments, provides health care for low-income individuals and others who meet the program's eligibility criteria. Medicaid is the single largest funding source for long-term care in the nation. In 2005, older people and people with disabilities accounted for two-thirds of national Medicaid expenditures.[2] More than a quarter of total Medicaid expenditures in the country were for the elderly.[3] In New York long-term care accounted for more than 42 percent of the state's Medicaid expenditures in 2006; 37 percent of that was spent on nursing facilities alone.[4] New York spent $21,223 per year for every Medicaid enrollee aged 65 or over in 2005, 1.8 times more than the national average ($11,839) in 2005.[5]

Medicaid takes both the income and resources of an applicant into account to determine eligibility. Income and resource limits vary by state and by beneficiary category, which includes single individuals or couples with or without children, pregnant women, people 65 years and older, and blind and disabled persons. In 2008, the Medicaid eligibility income limit in New York for a single elderly individual was $725 per month, or $8,700 per year, and the resource level was $13,050.[6] Those having more income or resources were not eligible for Medicaid.[7]

Some policymakers are concerned that elderly people with higher incomes transfer assets to become eligible for Medicaid-funded long-term care (usually nursing home or home health and personal care). For example, individuals may transfer assets by setting up a trust or purchasing annuities and promissory notes. They also can transfer assets by gifting them, by using personal service contracts with relatives to pay them for providing care, or by selling or transferring ownership of certain assets at less than fair market value. To help reduce long-term care costs and preserve the integrity of the Medicaid program, states are seeking ways to reduce asset transfers. Medicaid eligibility regulations allow states to examine individuals' financial, tax, and other records to determine whether they transferred assets to obtain Medicaid funding for their long-term care needs. A state can examine these records as far back as five years from the date of application (known as a "look back" period) to determine an applicant's eligibility. If an asset transfer is found within the look back period, the applicant is declared ineligible for Medicaid long-term care services for a period of time known as the "penalty period." In New York, asset transfer regulations apply only to people seeking Medicaid coverage for nursing facility services.[8] These regulations were strengthened with the adoption of the Deficit Reduction Act (DRA) of 2005. However,

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[2] "Older people" and "elderly" are defined as persons 65 years of age and older.
[3] Source: www.statehealthfacts.org/comparetable.jsp?ind=182&cat=4, accessed 1/12/2009.
[4] Sources: www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4; www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4, accessed 1/12/2009.
[5] Source: www.statehealthfacts.kff.org/comparetable.jsp?ind=183&cat=4, accessed 3/9/2009.
[6] Source: www.health.state.ny.us/health_care/medicaid/#qualify, accessed 1/9/2009. Note: Income and resource levels are subject to yearly adjustments.
[7] The income limit for an elderly person living with a spouse or with one other family member was $1,067 per month, or $12,800 annually, while the resource limit was $19,200. Excluded from the resource limits are an individual's house up to an equity value of $750,000, and their personal vehicle. Income and resources of relatives legally responsible for the applicant are included when determining eligibility. Persons admitted to a nursing home are allowed to keep a nominal amount of income for their personal use, and spouses residing in the community (commonly referred to as "community spouses") also are allowed to keep some income and assets.
[8] Source: NYSDOH. Note: Nursing facility services may include alternate care in a hospital, nursing home hospice services, intermediate care facility services, nursing home care, and nursing home managed long-term care.

many states lack ways to detect and estimate asset transfers, and people can find ways, usually through legal assistance, to shelter their assets from the state.

New York's Medicaid program covers about 4.1 million low-income beneficiaries.[9] The Office of Health Insurance Programs (OHIP) of the New York State Department of Health (NYSDOH) has statutory responsibility for Medicaid policy, program design, and overall administration. However, the Office of Temporary and Disability Assistance (OTDA) administers the Medicaid eligibility data system, along with several other social service and public assistance programs, as part of its Welfare Management System (WMS).[10] Statewide eligibility policies set by OHIP are carried out by 57 local social services departments, county government agencies, and by a separate system in New York City. Medicaid data and information collected by local workers are stored in the WMS.[11] OTDA operates the WMS; however, it does not instruct or supervise counties on implementation eligibility criteria for Medicaid applicants.[12] And because Medicaid eligibility data are stored by a separate agency, it can be difficult for DOH to extract and analyze these data quickly. DOH houses the Medicaid Automated Budgeting and Eligibility Logic (MABEL) system, which is used for calculating monthly "spend-down" amounts (called net available monthly income, or NAMI) and generating quarterly Medicaid reports.[13] MABEL uses WMS information for these calculations, but does not store historic data.[14] OHIP has a computer system that generates notices for Medicaid applicants and enrollees informing them about acceptances, denials, and status changes. This is known as the Client Notice System (CNS).[15]

This research explored ways to quantify asset transfers by Medicaid applicants in New York using data from the Department of Health and ODTA's Welfare Management System. As a first step in understanding asset transfer, this report describes the frequency of asset transfers detected when people applied for Medicaid nursing facility services in New York (excluding the five counties in the New York City region). It does not account for asset transfers that are done legally but that are difficult to detect given the current eligibility processes and data. It is conceivable that individuals could transfer assets within the five-year look back period, but such transfers might not be detectable through current data systems.

Information was analyzed for Medicaid applicants and enrollees in New York State (excluding New York City) aged 65 years and older who were denied Medicaid-funded nursing facility services during the period 1998-2008 due to asset transfer.[16] Even though enrollees have been denied nursing home

[9] Source: www.nyhealth.gov/nysdoh/medstat/el2007/2007-cy_eligibles.xls, accessed 3/2/2009.
[10] Source: www.uhfnyc.org/usr_doc/Reforming_New_York's_Medicaid_Eligibility_Process.pdf, accessed 1/12/2009.
[11] The Welfare Management System (WMS) at OTDA supports the delivery of temporary assistance, Medicaid, food stamps, adult services, and home energy assistance benefits to New Yorkers. It is made up of two separate systems: upstate WMS and downstate (New York City) WMS. Source: www.otda.state.ny.us/main/swms/default.asp.
[12] Source: NYSDOH.
[13] The analysis also examines spend-down information for persons who have applied for Medicaid but were denied eligibility because of asset transfers. "Spend-down" means that individuals, who at one time would fail to qualify for Medicaid due to excess income or assets, used private finances for health care expenses until they were poor enough to meet Medicaid eligibility requirements. [14] Source: NYSDOH.
[14] Source: NYSDOH.
[15] The Client Notice System (CNS) is a computer subsystem of the WMS that generates notices for clients in different public assistance programs related to their beneficiary status. OHIP uses CNS to generate client notices for Medicaid applicants and enrollees informing them about acceptances, denials, and status changes. There is a separate CNS unit for the NYC region for generating Medicaid notices, and a CNS unit at OTDA that handles notices regarding temporary assistance and food stamps. This report refers to OHIP's CNS unit.
[16] Medicaid beneficiaries 65 years old and over are enrolled in the Medicaid program's "aged" category. Medicaid long-term care may include nursing home care, home health, personal care, rehabilitation services, and intermediary care for the developmentally disabled.

services through Medicaid, they may continue to receive other Medicaid services such as home health care, personal care, inpatient or outpatient hospital services, preventive health and dental care, laboratory and X-ray services, and treatment in psychiatric hospitals. This paper analyzes spend-down information from WMS data for persons who applied for Medicaid nursing facility services, but were denied because of asset transfers.

One caveat should be noted when drawing conclusions from the WMS data. Because of one or more missing fields, only 53 percent of all denied cases could be used in these analyses. The denials that were analyzed may or may not have been representative of all denials. The paper also reviews previous studies on the likelihood of asset transfer by individuals with Medicaid funded long-term care, identifies New York data sources useful in estimating asset transfer, and identifies other states that are tracking asset transfer among the elderly.

Major Findings

A review of the literature found that there is little agreement among existing studies about the extent of asset transfers among the elderly. Some studies found the practice to be less prevalent. Others found that the elderly who still reside in their homes usually did not have enough assets to cover one year of nursing home expenses, even though most will require more than a year of nursing home care. Another study found that even a small asset transfer rate among the elderly could cause an increase in a state's Medicaid costs.

In examining New York's Medicaid databases, it was determined that the state has the capacity to systematically track the incidence of asset transfers among the elderly (by county and by certain demographic characteristics) once they applied for Medicaid. In analyzing New York's data the following was determined:

- Of the average number of elderly Medicaid enrollees in New York State (outside the New York City area), 7 percent were found to have transferred assets and were denied Medicaid nursing facility services between 1998 and 2008. However, this percentage may underestimate the total asset transfer rate, due to data limitations and because some people may have transferred assets in ways not detected by the state.
- Counties showed wide variation in reported asset transfer denial rates. Although most counties reported that less than 5 percent of elderly Medicaid enrollees were denied benefits due to asset transfers, about one of four counties denied more than 10 percent of such enrollees.
- It is not clear why counties differed so much in their denials of Medicaid nursing facility services due to asset transfers. Neither per capita income nor poverty rates were associated with the rate of asset transfer denials in a county; that is, counties with higher asset transfer rates did not necessarily have higher per capita average incomes or lower rates of poverty. It is possible that the asset transfer denial rates reflected in part differences in the intensity of county efforts to detect asset transfers.
- A total of 1,899 Medicaid enrollees were found to have spent down income or assets between 1998 and 2008. These enrollees were detected within the current data system because they were denied Medicaid nursing facility services at least once during this time period.

- Most spend-down cases (92.5 percent) had spent less than $200,000 between 1998 and 2008. Almost half of the cases spent down amounts between $10,000 and $50,000.
- In examining the policies and practices of six other states (California, Connecticut, Florida, New Jersey, Pennsylvania, and Washington), it was found that asset transfer data are not systematically tracked other than for determining eligibility. Information pertaining to asset transfer and eligibility is stored primarily at the county level in New York and in five of these six other states. These six states' systems for tracking asset transfer appear to be less sophisticated than what is now used in New York. All seven states have implemented provisions from DRA 2005 to lengthen look back and penalty periods.

Recommendations for Future Research

The research also uncovered potential opportunities for future analyses. For example, WMS data could be used to provide more detailed information about asset transfer cases among enrollees and applicants, the time taken to become eligible after assets have been spent down, geographical concentrations, and demographic composition.[17] Also, MABEL data could provide information on spend-down amounts, which could be used to analyze patterns.[18] An analysis of spend-down patterns may help in developing strategies to improve private long-term care insurance marketing so people would not have to spend down to qualify for long-term care services.

The following additional issues were identified for the New York State Department of Health as possible areas for further research:

For immediate action:

- Determine how variation in program implementation and regulatory enforcement at the county level might affect the asset transfer denial rate in different counties, and determine ways to effectuate more consistent regulatory enforcement.
- Investigate why certain counties have higher asset transfer denial rates and spend-down than others, and what factors contribute to such variation. Identifying causes of variance could point to areas where policy changes could minimize asset transfers. Also, research asset transfer denials from New York City's Medicaid data system.

For future action:

- Identify methods for proactively minimizing the occurrence of asset transfers, such as encouraging the purchase of long-term care insurance and strictly enforcing asset transfer and penalty period regulations.
- Evaluate the impact of New York's long-term care partnership program on asset transfers through an impact evaluation study or regression analysis.[19] Also, compare New York's long-

[17] The WMS records all spend-down amounts for each case by county. However, data provided for this analysis did not include enough information to calculate spend-down amounts for each case from the time of a first denial to subsequent acceptance and Medicaid enrollment.
[18] MABEL is used by NYSDOH to calculate monthly Medicaid spend-down amounts and also to generate monthly expenditure reports.
[19] Long-term care partnership programs are government initiatives to encourage people to purchase private insurance for their long-term care needs. The programs offer access to Medicaid beyond the terms of LTC insurance contracts if additional coverage is needed, while protecting some income and assets of the participants.

term care partnership program to similar programs in states like Connecticut and California to determine if changes could be made that would improve operation.

- Analyze spend-down patterns in more detail. An analysis of spend-down patterns may help identify where better marketing of private long-term care insurance is needed. A trend analysis of spend-down also could help identify regions where New York's long-term care partnership program could be better marketed.

I. Background on Medicaid, Long-Term Care, and Asset Transfer

A. Medicaid's Role in Financing Long-Term Care

Medicaid, a program funded jointly by the federal, state and, in some states, by county governments, provides health care for low-income individuals, the elderly, and people with disabilities. Medicaid is the single largest funding source for long-term care (LTC) in the nation. It pays for nearly half of all nursing home and community-based long-term care in the U.S., and six out of 10 nursing home residents have Medicaid as their primary payer.[20] In 2005 the elderly and people with disabilities, who consume more long-term care, accounted for two-thirds of Medicaid expenditures nationally.[21] In the same year more than a quarter of total national Medicaid expenditures were for the elderly.[22]

B. New York Medicaid and Long-Term Care

As a means-tested program, Medicaid takes both the income and resources (assets) of the applicant into account to determine eligibility. Income and resource limits vary by state.[23] As of April 2008, the income limit in New York for an elderly single individual was $725 per month, or $8,700 per year, and the asset limit was $13,050.[24] Income eligibility limits for an elderly person living with a spouse or with one other family member were set at $1,067 per month, or $12,800 annually, and the asset limit was $19,200. An individual's home up to an equity value of $750,000 and homes that are gifted or sold by the applicant to a spouse, a minor child, or other relatives at less than fair market value under certain conditions are exempt. [25] Personal vehicles also are excluded from the total amount of counted assets. However, income and resources of relatives legally responsible for the applicant are included when determining eligibility. Persons admitted to nursing homes are allowed to keep a nominal amount of income for their personal use. Spouses residing in the community (commonly referred to as a "community spouse") also are allowed to keep some income and assets.[26]

New York's Medicaid program is one of the largest in the country, covering about 4.1 million low-income beneficiaries (both adults and children).[27] New York spent $2,283 per capita on Medicaid — more than any other state (the national average is $1,026) in 2007.[28] New York's per enrollee

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[20] Ellen O'Brien and Risa Elias, *Medicaid and Long-Term Care,* Kaiser Commission on Medicaid and the Uninsured, May 2004.
[21] "Older people" and "elderly" refer to persons 65 years of age and older.
[22] Source: www.statehealthfacts.org/comparetable.jsp?ind=182&cat=4, accessed 1/12/2009.
[23] Different categories of Medicaid beneficiaries include single individuals with or without children, couples with or without children, pregnant women, people 65 years and older, and blind and disabled persons.
[24] Source: www.health.state.ny.us/health_care/medicaid/#qualify, accessed 1/9/2009. Note: Income and resource levels are subject to yearly adjustments.
[25] Applicants are allowed to transfer homes or other properties, without any penalty, to their spouses, a minor child under 21 years of age, a disabled child of any age, a sibling with an equity interest in that home and residing with the applicant in that home for at least one year prior to Medicaid application, or an adult child who resides with the applicant in that home and cared for the elderly applicant two years prior to application for Medicaid eligibility for nursing home care.
[26] Income and resource levels required for Medicaid eligibility are subject to yearly adjustment by the state. Source: www.health.state.ny.us/health_care/medicaid/#definition, accessed 1/9/2009.
[27] Source: www.nyhealth.gov/nysdoh/medstat/el2007/2007-cy_eligibles.xls, accessed 3/2/2009.
[28] *2009-10 Executive Budget* presentation (slide # 25), New York State, available at http://publications.budget.state.ny.us/eBudget0910/2009-10ExecutiveBudgetPresentation.pdf.

Medicaid spending was $7,733 in 2005, second only to Washington, DC ($7,941).[29] New York also spends the most in total dollars on long-term care. Total Medicaid long-term care spending in New York increased from $17.2 billion in 2004 to $18.9 billion in 2006.[30] Long-term care accounted for more than 42 percent of the state's Medicaid expenditures in 2006; 37 percent of that was spent on nursing facilities alone.[31] New York spent $21,223 per year for every Medicaid enrollee aged 65 or over in 2005, 1.8 times more than the national average ($11,839) in 2005.[32] New York's high level of Medicaid spending on long-term care may in part reflect the state's higher rate of poverty among residents 65 years and older (18 percent in 2006-2007) compared to the national average (13 percent in 2007).[33]

The New York State Department of Health (NYSDOH) has statutory responsibility for Medicaid program design and administration. The Office of Temporary and Disability Assistance (OTDA) has operational responsibility for the state's Medicaid eligibility data system.[34] OTDA operates the eligibility data system as a part of its Welfare Management System (WMS). The WMS manages the state's health, public assistance, and social service programs. DOH houses the Medicaid Automated Budgeting and Eligibility Logic (MABEL) system, which is used for calculating monthly spend-down amounts (called net available monthly income, or NAMI) and generating quarterly Medicaid reports.[35] MABEL uses WMS information for these calculations, but does not store historic data.[36] DOH's Office of Health Insurance Programs (OHIP) is responsible for Medicaid program policies such as establishing eligibility levels. OHIP has a computer system known as the Client Notice System (CNS), which generates notices for Medicaid applicants and enrollees informing them of acceptances, denials, and status changes.[37]

The statewide eligibility policies set by OHIP are carried out by 57 local social services departments, county government agencies, and by a separate system in New York City. However, workers implementing Medicaid eligibility and conducting necessary checks are employed by the local agencies, not by OHIP, which has no direct control over the implementation of eligibility policies at the ground level. OTDA does not administer Medicaid eligibility policies nor does it monitor eligibility.[38] County workers determine applicants' eligibility. The WMS stores Medicaid data from

[29] Source: www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4, accessed 12/15/2008. Note: This does not include disproportionate share hospital payments, which are payments to hospitals that treat high cost poor enrollees.
[30] Kaiser Commission on Medicaid and the Uninsured estimates based on data from the Centers for Medicare and Medicaid Services-64 reports at www.kff.org/medicaid/upload/kcmu032106table4.pdf and State Health Facts at www.statehealthfacts.org/profileind.jsp?ind=180&cat=4&rgn=34, accessed 1/5/2009.
[31] Sources: www.statehealthfacts.org/comparetable.jsp?ind=178&cat=4; www.statehealthfacts.org/comparetable.jsp?ind=180&cat=4, accessed 1/12/2009.
[32] Source: www.statehealthfacts.kff.org/comparetable.jsp?ind=183&cat=4, accessed 3/9/2009.
[33] Source: www.statehealthfacts.org/comparebar.jsp?ind=10&cat=1, accessed 2/11/2009.
[34] Source: www.uhfnyc.org/usr_doc/Reforming_New_York's_Medicaid_Eligibility_Process.pdf, accessed 1/12/2009. Note: OTDA also provides public assistance to New Yorkers through various welfare programs such as cash assistance and food stamps. It also monitors the state's child support enforcement program, implements Social Security Disability benefits, and supervises programs on homeless housing and services.
[35] "Spend-down" means that individuals, who at one time would fail to qualify for Medicaid due to excess income or assets, used private finances for health care expenses until they were poor enough to meet Medicaid eligibility requirements.[36] Source: NYSDOH.
[36] Source: NYSDOH.
[37] The Client Notice System (CNS) is a computer subsystem of WMS that generates notices for clients in different public assistance programs related to their beneficiary status. OHIP uses CNS to generate client notices for Medicaid applicants and enrollees informing them of acceptances, denials, and status changes. There is a separate CNS unit for the NYC region for generating Medicaid notices, and a CNS unit at OTDA that handles notices regarding temporary assistance and food stamps. This report refers to OHIP's CNS unit.
[38] Source: NYSDOH.

local case workers, and the only way OHIP and DOH can access these data is through an interagency request process. The fragmentation of New York's policymaking, data management, and implementation processes makes it difficult for state officials to assess need and make policy changes in a timely manner.

C. Medicaid Long-Term Care and Asset Transfer

Asset transfer is a practice whereby people with resources beyond the Medicaid eligibility level transfer all or a portion of their assets to become eligible for Medicaid. The practice is commonly associated with higher income individuals seeking funding for long-term care services, such as nursing home or home health and personal care. Various methods, like setting up a trust, purchasing annuities and promissory notes, gifting assets, using personal service contracts with relatives to pay them for providing care, and selling or transferring ownership of certain assets at less than fair market value may be used to transfer assets. This is referred to as "sheltering assets" or "estate planning." Most states want to minimize these practices, as they can increase Medicaid costs and affect the program's integrity as a safety net for the poor.

The Social Security Act prohibits individuals from transferring assets in order to qualify for Medicaid reimbursement for residence in long-term care facilities or for receiving home and community-based services (HCBS).[39] These provisions also may apply if the individual's spouse and/or anyone else acting on behalf of the applicant transfers assets.[40] The Social Security Act details regulations about the "look back" period (the period of time prior to when a person applies for Medicaid when the state can look back and check finance and tax records for proof of asset transfer). It also defines the "penalty period" (the period of denied eligibility from the time of application due to asset transfer). The Deficit Reduction Act (DRA) of 2005 introduced new regulations for look back and penalty periods, which are discussed further in the next section. In New York, asset transfer regulations apply only to people seeking Medicaid coverage for nursing facility services, and not other long-term care services like home health and personal care. Nursing facility services may include alternate care in a hospital, nursing home hospice services, intermediate care facility services, nursing home care, and nursing home managed long-term care.

D. Medicaid Long-Term Care Cost Control Efforts

Two strategies that states have used to slow Medicaid long-term care expenditure growth include: (1) preventing individuals from transferring assets in order to qualify for Medicaid-funded nursing care or home and community-based care; and (2) recovering the estates of deceased nursing home residents who used Medicaid to pay for their long-term care.

i. Medicaid Long-Term Care and the Deficit Reduction Act of 2005

Attempting to reduce the number of higher income elderly who transfer, shelter, and underreport assets to meet Medicaid asset eligibility requirements is difficult, but important, as research shows a substantial unmet need for long-term care services among the poor and low-

[39] See Section 1917(c) of the Social Security Act (U.S. Code Reference 42 U.S.C. 1396p(c)). Note: In New York, asset transfer prohibitions are not applicable to applicants or recipients of long-term care services under HCBS waiver programs: www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma018.pdf, accessed 3/11/2009.

[40] Source: www.cms.hhs.gov/MedicaidEligibility/10_TransferofAssets.asp#TopOfPage, accessed 1/9/2009.

income elderly.[41] To reduce asset transfers, Congress implemented restrictive policies against "Medicaid estate planning" or "asset transfers" in the Medicare Catastrophic Coverage Act of 1988, the Omnibus Budget Reconciliation Act (OBRA) of 1993, and, most recently, DRA 2005.

DRA 2005 attempted to prevent asset transfers by introducing stricter regulations. It increased the look back period; changed when a penalty period would start and how it would be calculated; allowed combining multiple asset transfers into a single asset transfer to decide the penalty period; changed regulations on purchasing promissory notes and life estates as assets; and adjusted home equity limits. As previously mentioned, the look back period is a time period when a state can look back (from the time the person applies for Medicaid) to review financial, tax, and other records of the applicant for any evidence of asset transfer. DRA 2005 increased the look back period from 36 months to 60 months. If evidence of an asset transfer is uncovered during the look back period, the penalty period, according to the new regulation, would start from the date of application rather than the date of transfer. Applicants are not eligible for Medicaid long-term care services during a penalty period.

Prior to DRA 2005, if transfers within a particular month were less than a state-determined threshold or a state's average monthly cost of private nursing home care, they were declared "partial month transfers" and no penalty period was assigned. This guideline enabled people to stay below the partial month threshold and avoid a penalty by transferring only small amounts each month. DRA 2005 requires that states calculate and impose penalty periods for these smaller transfers. It also grants states the ability to impose a single period of ineligibility for multiple asset transfers instead of imposing several partial penalty periods for each of those transfers. This allows states to treat the cumulative value of all assets transferred during the look back period as a single transfer. New York began implementing these changes in 2006.

ii. Medicaid Estate Recovery

The federal government has mandated estate recovery since OBRA 1993.[42] OBRA requires states to recover Medicaid spending from beneficiaries' estates upon their death.[43] Estates of persons receiving Medicaid services after age 55 and those permanently institutionalized (regardless of age) are affected under this regulation. A state is required to pursue recoveries from the probate estate, which, under state probate law, includes property that passes to heirs. Additionally, states may expand the definition of "estate" to allow recovery from property that bypasses probate, including property owned in joint tenancy with rights of survivorship, life estates, living trusts, annuity remainder payments, or life insurance payouts. States also may recover amounts spent by Medicaid for long-term care and related drug and hospital benefits, including any Medicaid payments for Medicare cost-sharing related to these services. States also

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[41] Ellen O'Brien, *Medicaid and Long-Term Care: Understanding Medicaid's Role for the Elderly and Disabled,* Kaiser Commission on Medicaid and the Uninsured, November 2005.

[42] The mandate was imposed by Section 13612 of P.L. 103-66 (OBRA 1993), which amended Section 1917 of the Social Security Act; available at: www.ssa.gov/OP_Home/ssact/title19/1917.htm accessed 10/7/2008. Detailed federal guidance to states is in the State Medicaid Manual, Chapter 3, Section 3810, cited at: http://aspe.hhs.gov/daltcp/reports/estaterec.htm, accessed 10/7/2008.

[43] Source: www.cms.hhs.gov/MedicaidEligibility/08_Estate_Recovery.asp, accessed 11/5/2008.

may employ other options to recover costs from Medicaid services paid on the individual's behalf.[44]

States differ in their policies and practices regarding Medicaid estate recovery. Eight states implemented policies that followed the minimum federal law requirements in 2005. Twenty-nine states, including New York, used a mix of policy options. Only nine states made maximum use of federal policy options for estate recovery during this period.[45] New York, along with four other states — California, Connecticut, Indiana, and Iowa — adopted state plans in 1993 to exempt some federal laws regarding estate recovery.[46] These states are not required to comply with the federal estate recovery regulations for persons with private long-term care insurance. However, they must comply with the federal estate recovery provisions for individuals without private LTC insurance. In 2005, New York collected $34.4 million from Medicaid estate recoveries, a sum that amounted to only 0.2 percent of its total long-term care spending.[47]

E. Findings from the Literature

Despite efforts by states to reduce the incidence of asset transfers, studies have shown that the practice still occurs. However, the studies do not agree about the size of the problem. Some have noted that it is prevalent among higher income individuals.[48] Some argue that estate planning to shelter assets has become increasingly common among the elderly in recent years, and others found that while a small percent of the elderly transferred only modest assets, the total amount was not trivial.[49] Other researchers argue that there is little quantitative evidence in the literature that asset transfers are common, in part because there is little or no systematic tracking of people who engage in this practice.[50] Some research has found that most elderly who have the means to pay for their nursing home care do so without depending on Medicaid.[51]

Estimates from the U.S. Government Accountability Office (GAO) for eight states and the District of Columbia show that 22 percent of elderly households had transferred assets two years prior to when the survey was conducted.[52] A report by the Kaiser Commission on Medicaid and the Uninsured estimated that approximately 9 to 19 percent of Medicaid nursing home residents transferred assets, and most Medicaid nursing home residents had few assets prior to admission.[53]

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[44] Ibid.

[45] Source: http://assets.aarp.org/rgcenter/il/2007_07_medicaid.pdf, accessed 12/4/2008.

[46] Note: The mandate was imposed by Section 13612 of P.L. 103-66 (OBRA 1993).

[47] Source: http://aspe.hhs.gov/daltcp/reports/estreccol.htm, accessed 2/16/2009.

[48] Jinkook Lee, Hyungsoo Kim, and Sandra Tanenbaum, "Medicaid and Family Wealth Transfer," *The Gerontologist* 46, no. 1 (2006): pp. 6-13; B. Burwell, and W. H. Crown, "Medicaid Estate Planning: Case Studies of Four States," in Joshua M. Wiener, Steven B. Clauser, and David L. Kennel, eds., *Persons with Disabilities: Issues in Health Care Financing and Service Delivery*. Washington, D.C., Brookings Institution, 1995 (pp. 61-93); J. Gary, "Governors Seek to Shed Burdens of Medicaid," *The New York Times*, August 4, 1992, p. A8; Joshua M. Wiener, "Public Policies on Medicaid Asset Transfer and Estate Recovery: How Much Money To Be Saved?" *Generations*, 20, No. 2, fall 1996, pp. 72-77; M. W. Serafini, "Plugging a Big Drain on Medicaid," *National Journal* 27, March 18, 1995, p. 687; Stephen A. Moses, "The Long-Term Care Financing Crisis: Danger or Opportunity," Kirkland, WA: LTC, Inc., 1995, cited in Wiener, "Public Policies."

[49] Serafini, "Plugging a Big Drain"; Moses, "The Long-Term Care Financing Crisis"; and Lee et al., "Medicaid and Family Wealth Transfer."

[50] Wiener, "Public Policies."

[51] Ellen O'Brien, *Medicaid's Coverage of Nursing Home Costs: Asset Shelter for Wealthy or Essential Safety Net?,* Georgetown University Long-Term Care Financing Project, Issue Brief, May 2005.

[52] U.S. Government Accountability Office, *Medicaid: Transfers of Assets by Elderly Individuals to Obtain Long-Term Care Coverage,* Report to Congressional Requesters, September 2005. Note: This report was based on the Health and Retirement Study conducted by the University of Michigan. The states included in the study are: Arkansas, Florida, Hawaii, Montana, Ohio, Oregon, South Carolina, and Wisconsin, plus the District of Columbia.

[53] *Asset Transfer and Nursing Home Use,* Kaiser Commission on Medicaid and the Uninsured, November 2005.

Another Kaiser study found that most of the elderly who still reside in their communities do not have sufficient assets (except homes) to cover nursing home needs for more than one year.[54] Most of the people likely to need nursing care for more than a year are 85 years and older, female, without a spouse, and with limited functional and cognitive abilities. Few of these individuals are likely to have substantial incomes or assets. Also, analyses of historical asset transfers (transfers two to four years prior to nursing home admission) among both Medicaid and non-Medicaid residents suggest that consideration of nursing home use or payment for long-term care played little part in decisions to transfer assets to children, grandchildren, or other relatives.[55]

A Centers for Medicare and Medicaid Services (CMS) study in five states (Arizona, Maryland, Missouri, Nebraska, and Pennsylvania) found that even a 1.5 percent average asset transfer rate from annuity purchases could cost a state an average of $13 million per year for institutionalized Medicaid beneficiaries.[56] The study used the results to calculate Medicaid long-term care costs from annuity purchases, and estimated the annual cost to be about $200 million nationally (for 43 states and the District of Columbia). This indicates that $200 million could be saved nationally if people paid for their LTC needs through private resources instead of sheltering assets through annuity purchases. However, according to the study, each state potentially could save up to $4.5 million by regulating annuity purchases, depending on demography, incidence of purchases, and Medicaid LTC eligibility criteria. The study also found that those who purchased annuities to shelter assets were more likely to have used other methods to avoid spending their own money on long-term care and also were more likely to have a spouse living in the community. In 2006, the U.S. Office of Management and Budget (OMB) estimated that tightening asset transfer regulations would potentially save an estimated $4.5 billion over a 10-year period.[57]

II. Data and Methods

As this research commenced, it was unknown what, if any, data regarding asset transfers in New York State were available. After consulting with DOH staff, it was determined that the WMS and MABEL data systems potentially could track asset transfers in New York State (excluding the five counties in New York City, as information for NYC is stored in a separate system). As previously mentioned, MABEL is used to calculate monthly spend-down contributions and generate Medicaid quarterly reports. It also contains information on enrollment categories. It was unclear what asset transfer information could be obtained from the WMS or MABEL. What was known was that individuals who transferred assets prior to applying for Medicaid and beyond the look back period could not be tracked with existing data. It also was unclear whether the WMS captured all of the people who planned their estates with legal assistance to avoid detection by the state. Such cases are hard to detect even if the transfer occurred within the look back period.

[54] *The Distribution of Assets in the Elderly Population Living in the Community,* Kaiser Commission, June 2005.
[55] Ibid.
[56] An annuity contract in the U.S. involves a financial investment by an individual through an agent (e.g., a life insurance company) so that it grows on a tax-deferred basis and can later be distributed back to the individual). These are defined by an IRS code, but are regulated at the state level. Basic types of annuities can be either fixed or variable depending on the type of payments they generate and the type of investment options they offer. This is just one of the ways used to divert or shelter assets to obtain Medicaid eligibility. Source: www.cms.hhs.gov/MedicaidEligibility/downloads/annuities.pdf, accessed 1/9/2009.
[57] Source: www.whitehouse.gov/omb/budget/fy2006/pdf/savings.pdf, accessed 3/4/2009.

This analysis used WMS data to describe the cumulative frequency and geographic location of asset transfer denials. HPRC staff examined the Client Notice System for New York (excluding NYC) to determine how to obtain information on individuals who were denied Medicaid coverage for nursing facility services due to asset transfer. The CNS included case and status codes for each record. From approximately 2,124 case reason codes, 95 pertained to people having excess income or resources.[58] (For a full description of the various codes, data, and processes used for this analysis, see Appendices 1-4.) However, the codes did not indicate whether these people were asset transfer cases. Further discussion with OHIP staff resulted in identifying coverage code "MA10," which is assigned to individuals who were denied Medicaid funding for nursing facility services because they had transferred assets during the look back period (marked as code "B 10" in Appendix -3). A nonrandom part of the population of MA10 cases was extracted from the WMS by OHIP staff for a period of 10 years (1998-2008) and provided for our analysis.

As with any administrative data, this dataset contained many duplicate cases and missing values. After cleaning the data, 11,526 unique (nonduplicate) cases were obtained from the total population of asset transfer denials in New York (excluding the NYC region). About 47 percent (5,462) of these cases were missing Medicaid district (county) information. It could not be determined why these cases were missing this information, and it was unclear how they differed from the remaining 53 percent (6,064 cases). This discrepancy might be due to differences in counties' capabilities to enter, maintain, and store these data at the local level, or it might result from gaps in the WMS data. Failure to transfer data accurately from paper documents to electronic format also may have contributed to information gaps. The analyses were conducted under the assumption that the cases with complete data were representative of asset transfer denial cases. The number of asset transfer denial cases was compared with the average number of Medicaid elderly enrollees per county, the average percent of residents below poverty per county, and counties' rankings based on per capita personal income for similar time periods.[59]

Information regarding spend-down amounts was also analyzed for the same time period. Spend-down information was drawn from a larger set of Medicaid enrollees than the denial cases included in the first part of this analysis (Section III. A.) because of WMS data extraction limitations. It should be noted that some asset transfer denial cases may have spend-down amounts recorded in different counties, depending on when and where Medicaid services were obtained or where excess medical expenses were incurred. As Medicaid applicants move from one county to another, it is possible that an applicant can be denied in one county and then reapply in another county at a later date and be accepted. If the person continued to incur spend-down during this time, it might be registered in different counties.[60] Because of data limitations, it was not possible to separate these types of cases from the rest of the data. Conversely, it may also be possible that spend-down information was only recorded the first time someone applied in a county but was not recorded if the person subsequently migrated to a different county. It was unclear from the available data if such discrepancies might have occurred at the county

[58] The Client Notice System (CNS) generates notices for Medicaid applicants in upstate New York. See Appendix 1 for details.
[59] At the time of this analysis, enrollment data were available for 1998-2007; poverty data were available for 1998-2005 and the most recent information on ranking based on per capita personal income was from 2006.
[60] Source: OHIP.

level. Also, differentiating between the time of denial and the time of spend-down for these cases was not possible, as the data were provided in a 10-year aggregate format. [61]

In addition to analyzing New York data, this report also analyzed information obtained from interviewing state officials in six other states: California, Connecticut, Florida, New Jersey, Pennsylvania, and Washington. The information obtained was compared with what was available for New York to determine how and if other states track spend-down amounts and asset transfers and attempt to minimize the latter.[62]

III. Findings

A. Asset Transfer Cases

Table 1 indicates where Medicaid coverage for nursing facility services was denied between 1998 and 2008 due to asset transfers, and is ranked by the percentage of the average number of Medicaid enrollees in the "aged" category.[63] Also included are denial data on facilities under the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD).[64] The table provides a comparison by county of the average percent of the population below the poverty level (1998-2005), and per capita income ranking (2006) in relation to the percent of asset transfer cases among Medicaid elderly enrollees.

[61] Further detailed data extraction is needed to obtain a clear picture of spend-down and its magnitude in New York.
[62] These six states were a subset of states previously selected in consultation with staff from the New York State Department of Health.
[63] The Medicaid "aged" category enrolls people 65 years of age or older. This category also is referred to as "Medicaid elderly enrollees."
[64] People receiving Medicaid long-term care in OMH and OMRDD facilities are considered Medicaid enrollees and are subject to all eligibility regulations; therefore, OMH and OMRDD are termed as Medicaid districts.

Table 1: Asset Transfer Cases* Denied Medicaid Nursing Facility Services in New York (Excluding Five Counties in New York City), 1998-2008

NYS Medicaid Districts	Average Total Population (1998-2007)	Average Medicaid Elderly Enrollees (1998-2007)	Elderly* Who Transferred Assets and Were Denied Medicaid Nursing Facility Services (1998-2008)	% of Elderly Medicaid Enrollees Denied Nursing Facility Services Due to Asset Transfers (1998-2008)	Average % of County Residents Below Poverty (1998-2005)	Per Capita Personal Income Rank (2006)
Franklin	50,585	497	243	48.9	15.4	60
Schoharie	31,739	304	133	43.8	12.0	40
Delaware	47,261	508	177	34.9	13.3	45
Clinton	80,943	756	220	29.1	13.0	41
Otsego	62,050	571	152	26.6	12.6	46
Jefferson	114,068	1,064	258	24.2	14.2	20
Rockland	291,259	2,214	535	24.2	9.7	4
Ulster	179,438	1,519	343	22.6	10.8	22
Tioga	51,290	459	71	15.5	9.4	37
Saratoga	207,160	1,333	194	14.6	6.4	10
Suffolk	1,440,228	8,452	1,226	14.5	6.7	6
Ontario	101,815	827	116	14.0	8.1	17
Putnam	97,541	442	60	13.6	4.2	5
St. Lawrence	110,852	1,205	129	10.7	15.7	61
Livingston	63,936	405	39	9.6	10.7	47
Steuben	98,133	1,072	101	9.4	13.3	15
Cortland	48,609	518	46	8.9	13.5	55
Onondaga	457,385	3,359	277	8.2	11.9	13
Cayuga	81,216	863	56	6.5	11.8	44
Monroe	733,583	5,402	343	6.3	12.0	11
Oswego	122,219	782	43	5.5	13.3	56
Nassau	1,325,972	8,945	486	5.4	5.7	3
Wayne	92,778	648	34	5.3	9.6	26
Sullivan	74,501	742	36	4.9	14.0	25
Chemung	89,894	1,051	42	4.0	13.2	36
Albany	297,136	2,276	85	3.7	10.4	7
Genesee	59,545	508	16	3.1	9.1	38
Greene	48,530	435	12	2.8	12.9	31
Essex	38,541	422	10	2.4	11.9	39
Hamilton	5,230	43	1	2.3	9.6	24
Oneida	233,737	2,788	65	2.3	13.5	30

Table 1: Asset Transfer Cases* Denied Medicaid Nursing Facility Services in New York (Excluding Five Counties in New York City), 1998-2008 (cont.)

NYS Medicaid Districts	Average Total Population (1998-2007)	Average Medicaid Elderly Enrollees (1998-2007)	Elderly* Who Transferred Assets and Were Denied Medicaid Nursing Facility Services (1998-2008)	% of Elderly Medicaid Enrollees Denied Nursing Facility Services Due to Asset Transfers (1998-2008)	Average % of County Residents Below Poverty (1998-2005)	Per Capita Personal Income Rank (2006)
Warren	64,334	611	14	2.3	10.2	23
Broome	198,705	2,092	43	2.1	12.9	28
Erie	937,422	7,918	166	2.1	12.5	14
Lewis	26,593	334	7	2.1	13.1	58
Seneca	34,139	280	6	2.1	11.6	42
Allegany	49,992	451	9	2.0	15.7	62
Schuyler	19,163	204	4	2.0	12.0	49
Tompkins	98,673	468	9	1.9	13.4	29
Washington	61,589	579	11	1.9	11.3	50
Columbia	62,913	573	10	1.7	10.1	16
Niagara	217,787	1,752	30	1.7	11.2	32
Chenango	51,231	581	8	1.4	13.7	48
Orange	356,803	2,671	38	1.4	10.3	21
Fulton	54,978	828	11	1.3	13.0	34
Herkimer	63,576	753	10	1.3	12.3	51
Madison	69,630	523	7	1.3	10.3	33
Montgomery	49,234	694	9	1.3	13.4	35
Rensselaer	153,340	1,423	19	1.3	10.1	19
Schenectady	147,812	1,250	15	1.2	10.7	12
Yates	24,500	185	2	1.1	13.0	53
Duchess	285,999	1,759	18	1.0	7.5	9
Orleans	43,387	370	3	0.8	12.1	57
Wyoming	42,789	367	3	0.8	9.8	54
Cattaraugus	82,594	947	7	0.7	13.5	43
Westchester	936,871	7,130	38	0.5	8.3	2
Chautauqua	137,375	1,608	4	0.2	14.8	52
OMH	--	--	10	--	--	--
OMRDD	--	--	4	--	--	--
Mean	193,133	1,522	103	8.2	11.5	--
Total	11,008,603	86,759	6,064	7.0		

Notes: *This may include people 55 years and older who were denied Medicaid nursing facility services because they had transferred assets; higher rank means lower per capita personal income. The 2006 per capita ranking is for the entire state, including the NYC region. Acronyms — OMH: New York State Office of Mental Health; OMRDD: Office of Mental Retardation and Developmental Disabilities.

Sources: WMS data from the New York State Office of Health Insurance Programs; U.S. Bureau of the Census; Empire State Development, State Data Center; available at www.nylovesbiz.com/nysdc/popandhous/ESTIMATE.asp, accessed 11/3/2008; http://quickfacts.census.gov/qfd/states/36000.html accessed 10/17/2008; www.health.state.ny.us/nysdoh/medstat/medicaid.htm#table1 accessed 10/17/2008; U.S. Bureau of Economic Analysis, Regional Economic Information System 1969-2008, May 2008. Table prepared by Empire State Development, available at www.nylovesbiz.com/nysdc/Personalincome/PCPICounty0006.pdf, accessed 10/16/2008.

- Among the 6,064 total occurrences in the sample where asset transfer was the reason for denial of Medicaid coverage for nursing facility services, the highest number — 1,226 — was reported in Suffolk County, followed by 535 in Rockland, 486 in Nassau, and 343 in both Monroe and Ulster counties. These figures represent people who applied for Medicaid and were denied nursing facility services. It does not include applicants who transferred assets during the look back period in ways not detected by the WMS.
- Of the average number of elderly Medicaid enrollees in the state (excluding NYC) 7 percent were found to have transferred assets between 1998 and 2008 and were denied Medicaid nursing home facility services.[65] County asset transfer denial rates varied widely. The percentage of asset transfer cases ranged from 0.2 percent in Chautauqua County to 48.9 percent in Franklin County. The mean rate across counties was 8.2 percent, with a standard deviation of 11.0. This large standard deviation indicates that the percentage range is spread widely across the 57 counties. Eighteen counties had an asset transfer denial rate that was greater or equal to 8.2 percent (the mean of county rates).[66] However, the rate of denial due to asset transfer in half of the counties was less than 2.4 percent (the median value). Franklin, Schoharie, Delaware, and Clinton counties had considerably higher asset transfer percentages than the 7.0 percent state average and the sample's average of 8.2 percent.
- Counties with higher asset transfer denial rates did not necessarily have higher average per capita incomes or lower rates of poverty. For example, Allegany and St. Lawrence counties had the same 15.7 percent poverty rate (the highest among all counties excluding NYC), but Allegany County had a lower asset transfer denial rate than St. Lawrence (2.0 percent vs. 10.7 percent). And although Franklin County's 15.4 percent poverty rate was similar to Allegany and St. Lawrence, its 48.9 percent asset transfer denial rate was significantly higher than either of those two. When the 14 counties with higher asset transfer denial rates (greater than 10 percent between 1998 and 2005) were considered, the average poverty rate varied considerably, from 4.2 percent to 15.7 percent.
- Chautauqua County had low per capita income and only a 0.2 percent asset transfer denial rate in 2006.[67] Franklin County also had very low per capita income. However, it had significantly more asset transfer denial cases than many other low-income counties in New York State.

[65] This includes only those cases captured by WMS in 57 Medicaid districts, plus facilities under OMH and OMRDD.
[66] Rank ordered by percent of Medicaid aged enrollees denied Medicaid long-term care due to asset transfers.
[67] Per capita rankings are for all 62 counties in New York State including NYC, but asset transfer figures are for 57 districts (excluding NYC).

B. Spend-Down Cases

Individuals who fail to qualify for Medicaid due to excess income and resources must use private finances for their health care expenses until their income and assets are reduced enough to meet Medicaid eligibility requirements.[68] Once they exhaust their private finances they may reapply for Medicaid. This is commonly known as "spend-down." In cases where individuals apply for Medicaid to receive nursing home care, the amount of time it takes for individuals to spend down may be faster in New York than in other states because the cost of nursing home care is more expensive in New York.

The asset transfer analysis examined cases where resources had been spent down, including how much was spent. The amount of spend-down is calculated first by subtracting Medicaid allowable income for nonmedical expenses from the individual's monthly income. The remaining net amount available for medical expenses, called net available monthly income, or NAMI, is calculated to determine the appropriate spend-down amount. In cases where the individual applying for Medicaid is married, the spouse's income also is considered when calculating the amount of spend-down. NAMI amounts are used to help determine how much excess income and resources individuals are likely to divest to qualify for Medicaid-funded long-term care, thereby providing some sense of the level of wealth of individuals tracked by the WMS.

A total of 1,899 Medicaid enrollees were found to have spent down income or assets between 1998 and 2008. These enrollees were detected within the current data system because they were denied Medicaid nursing facility services at least once during the 10-year time period. These cases were spread across 20 of 57 counties (excluding NYC).[69] The information was drawn from a larger set of asset transfer denial cases than those included in the previous section's analysis due to WMS data extraction limitations. It was not possible to differentiate between the time of denials and the time of spend-down from the 10-year aggregate data.

Table 2 shows the distribution of spend-down by county, as well as the range of how much was spent down. The counties are rank ordered according to the total number of spend-down cases.

[68] As of 2008, the income limit in New York for an elderly single individual was $725 per month, or $8,700 per year, and the asset limit was $13,050. Eligibility income limits for an elderly person living with a spouse or with one other family member was set at $1,067 per month, or $12,800 annually, and the asset limit was $19,200. An individual's home up to an equity value of $750,000, and homes that are gifted or sold by the applicant to a spouse, a minor child, or other relatives at less than fair market value are exempt. Personal vehicles also are excluded from the total amount of counted assets. Source: www.health.state.ny.us/health_care/medicaid/#qualify, accessed 1/9/2009.

[69] It could not be determined whether the data from these 20 counties include all spend-down cases in the state or whether such data are only collected by the 20 counties reporting this information.

Table 2: Distribution of Spend-Down Ranges Among Asset Transfer Cases Denied Medicaid Nursing Facility Services in New York (Excluding the Five Counties in New York City), 1998-2008

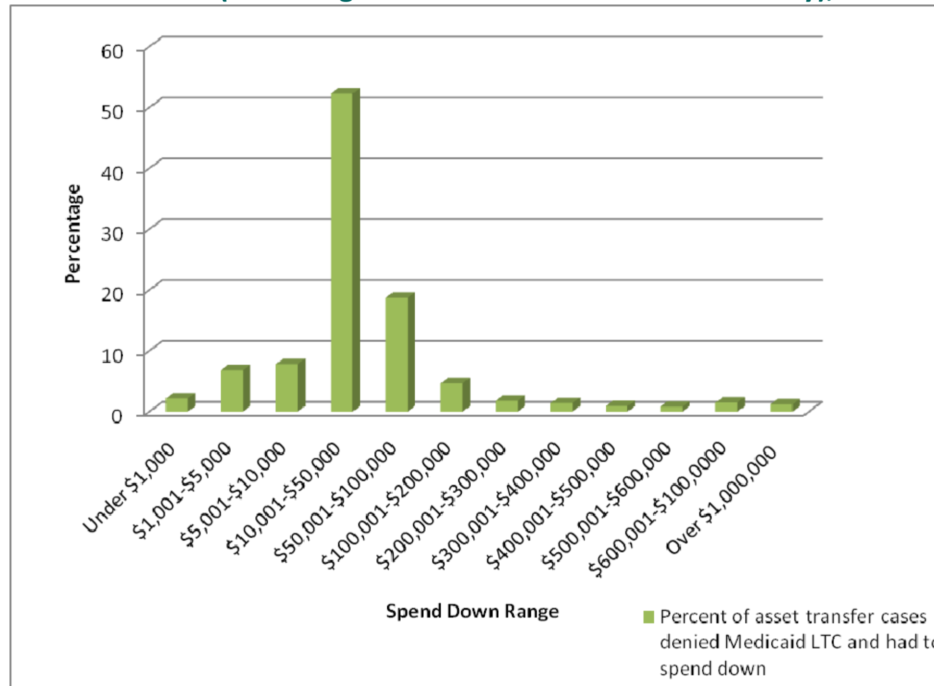
Counties \ Spend-Down Ranges	Under $1,000	$1,001-$5,000	$5,001-$10,000	$10,001-$50,000	$50,001-$100,000	$100,001-$200,000	$200,001-$300,000	$300,001-$400,000	$400,001-$500,000	$500,001-$600,000	$600,001-$1,000,000	Over $1,000,000	Total	Percentage
Ontario	18	53	61	366	156	35	13	15	6	4	13	8	**748**	**39.4%**
Steuben	8	29	29	218	53	22	1	3	1	1	2	2	**369**	**19.4%**
Suffolk	2	9	16	124	43	9	8	1	3	4	5	4	**228**	**12.0%**
Chemung	3	11	9	92	34	10	6	3	4	4	5	3	**184**	**9.7%**
Nassau	1	7	2	39	19	2	3	2	1	1	1	--	**78**	**4.1%**
Livingston	1	1	7	41	9	4	--	--	1	--	1	--	**65**	**3.4%**
Saratoga	--	5	9	45	4	1	--	--	--	--	--	--	**64**	**3.4%**
Seneca	5	5	4	13	6	1	--	--	--	--	--	2	**36**	**1.9%**
Monroe	--	3	--	10	3	2	1	1	--	--	2	--	**22**	**1.2%**
Franklin	1	1	1	7	8	--	--	--	--	--	--	--	**18**	**0.9%**
Allegany	1	2	1	5	7	--	--	--	--	--	--	--	**16**	**0.8%**
Wayne	--	--	2	7	2	2	1	--	--	--	--	--	**14**	**0.7%**
Schuyler	--	1	1	6	3	--	1	--	--	--	--	--	**12**	**0.6%**
Ulster	--	1	1	7	1	--	--	1	1	--	--	--	**12**	**0.6%**
Jefferson	--	--	2	5	2	--	--	--	--	--	--	2	**11**	**0.6%**
Washington	--	--	1	1	2	--	--	--	--	1	--	--	**5**	**0.3%**
Orleans	--	--	1	1	1	--	--	--	--	--	--	1	**4**	**0.2%**
Schoharie	--	1	--	2	1	--	--	--	--	--	--	--	**4**	**0.2%**
Tioga	1	--	--	2	--	1	--	--	--	--	--	--	**4**	**0.2%**
Yates	--	--	--	2	2	--	--	--	--	--	--	--	**4**	**0.2%**
OMRDD	--	--	1	--	--	--	--	--	--	--	--	--	**1**	**0.1%**
Total	**41**	**129**	**148**	**993**	**356**	**89**	**34**	**26**	**17**	**15**	**29**	**22**	**1899**	**100%**

Note: Data were not available for all counties. Source: WMS data from the New York State Office of Health Insurance Programs.

- From the available data, it was determined that approximately 35 percent of the counties in the state (excluding NYC) had information about spend-down cases. Cases with spend-down information were spread across 20 of 57 Medicaid districts, plus one case at OMRDD.
- Of the 1,899 cases, approximately 40 percent occurred in Ontario County, 19 percent occurred in Steuben County, and 12 percent were in Suffolk County.
- The amount of total spend-down contributions from 1998-2008 ranged from under $1,000 to over $1 million.

Figure 1 shows the distribution of asset transfer cases with spend-down information.

Figure 1: Percent Distribution of Asset Transfer Denial Cases by Spend-Down Ranges in New York State (Excluding the Five Counties in New York City), 1998-2008



Source: WMS data from the New York State Office of Health Insurance Programs.

- More than 88 percent of the cases had spent down less than $100,000 between 1998 and 2008. Over half (52 percent) of these cases had spent down between $10,001 and $50,000, and approximately 19 percent spent down between $50,001 and $100,000. Figure 1 depicts the percentage distribution of spend-down amounts by spend-down range.[70] These cases were denied nursing facility services under Medicaid and had spent down to meet eligibility requirements. The data are inconclusive regarding whether these cases eventually qualified for Medicaid and, if so, the amount of time it took for them to reapply and qualify.

C. How Other States Are Addressing Asset Transfer Issues

In addition to the analysis of New York State-specific data, six other states (California, Connecticut, Florida, New Jersey, Pennsylvania, and Washington) were contacted to learn if there may be better ways to track asset transfers.[71] Officials in these states indicated that tracking asset transfers among the elderly was difficult, and that New York's WMS appeared to be more sophisticated than other state systems. The WMS stores a great deal of information regarding spend-down and asset transfers detected within the look back period. Among the six states contacted, only Florida indicated they had a formal computer system in place to determine and store Medicaid eligibility information. The state mainly uses this system to send notices to Medicaid applicants and enrollees about penalty periods. This is somewhat similar to New York's Client Notice System. According to

[70] Age and gender information were unavailable for analysis.
[71] These six states were a subset of states previously selected in consultation with staff from the New York State Department of Health.

the officials, except for a series of focus groups in Connecticut in the 1990s, there has been no formal analysis of asset transfer in any of the six states.

It was evident from discussions with officials in these states that in spite of a lack of data, the states are trying to reduce asset transfers. Some have initiated long-term care partnership programs, which encourage individuals to buy private long-term care insurance by allowing them to eventually rely on Medicaid to fund their long-term care without having to divest their assets. The programs offer access to Medicaid beyond the terms of LTC insurance contracts if additional coverage is needed, while still protecting some assets and income. The eligibility rules, structure, and requirements of partnership programs vary among states. The goal of the programs is to use private long-term insurance rather than Medicaid as a payment source for long-term care. New York has had a long-term care partnership program since the early 1990s, but the impact of the program on asset transfer in the state has yet to be evaluated. Of the six states contacted for this research, Connecticut also initiated its LTC partnership program in the early 1990s, while New Jersey started its program in 2008.

Another strategy being used by these states to reduce asset transfer is modifying personal service and personal care contracts. Personal care contracts are legal contracts between an elderly individual who resides in the community and relatives or friends who provide care to them. If there is no legal contract in place for this type of informal care, then any money paid by the elderly person to the caregiver is considered a gift and designated an asset transfer.[72] However, if an elderly individual enters into a legal personal care contract, they can avoid having that payment counted as an asset. This could enable the individual to subsequently apply for Medicaid. In some states, when an elderly individual shelters assets through a legal personal care contract, Medicaid ends up paying for that care. States are becoming more vigilant about such duplication.[73] For example, New Jersey closely monitors personal care contracts, especially those of Medicaid funded nursing home residents, by requiring family members to keep detailed logs of care giving acts. This enables officials to check the logs during the eligibility determination process to ensure that there is no duplication of services by the nursing home and the family caregiver. In New York, personal care contracts are examined by state eligibility officials to ensure they are legitimate. If legitimacy cannot be proved, it is considered an improper transfer of assets and the applicant is denied Medicaid nursing facility services. Apart from regulating and monitoring personal care contracts, states are trying to tighten Medicaid eligibility regulations. For example, officials in Florida indicated they have begun an administrative rulemaking process to develop specific statutory language to ensure that people who shelter assets meet more restrictive eligibility criteria.

Officials in the six states also believe they have already mitigated asset transfers, especially in the case of annuities, by implementing provisions from DRA 2005. For example, New Jersey is

[72] "Personal care contracts" are also known as "caregiver agreements" in some states.

[73] Sometimes caregivers enter into personal care contracts with elderly family members or friends in nursing homes. If the nursing home bills Medicaid for the same services, then it is considered duplication. States are becoming more vigilant about detecting this type of duplication. For more information on personal care contracts see: www.dvanarelli.com/blog/2008/12/18/director-of-medicaid-upholds-the-denial-of-nursing-home-medicaid-benefits-to-applicants-who-paid-family-members-for-care-under-life-care-contracts/; www.kcelderlaw.com/blog/kansas-and-missouri-medicaid/personal-care-contracts/; and www.elderlawanswers.com/resources/article.asp?id=5646§ion=4&state, accessed 3/4/2009.

implementing stricter case level monitoring, changing the definition of “resources” to include annuities, and systematically monitoring personal care contracts. Officials in most of the six states are checking income tax returns to monitor more closely the amount of money that Medicaid applicants or enrollees have gifted to their children or others, and that the amount of interest gained on promissory notes is reflected on tax returns. As these states have only recently begun implementing DRA provisions, it will take some time to evaluate the impact of these changes on asset transfers.

Appendix 5 summarizes in more detail the responses from the six interviewed states and New York regarding how asset transfers are tracked and how such information is stored after people have applied for Medicaid.

IV. Discussion

This report analyzed the New York State Welfare Management System’s asset transfer denial data from 1998 to 2008. The data indicated that of the average number of elderly Medicaid enrollees applying for Medicaid funding for nursing facility services during this period, 7 percent were found to have transferred assets and were denied coverage. The analysis found great variation among counties in the rate of denials due to asset transfers. While most counties had denial rates under 3 percent, about one-fourth of the counties had rates above 10 percent, and as high as 49 percent. The analysis also found that spend-down amounts were smaller, commonly ranging between $10,001 and $50,000. Less than 10 percent of all of spend-down cases were over $400,000.

Interpreting these numbers is not easy because the data are limited. First, 47 percent of denial cases had missing fields and could not be included in the analyses. Second, data on persons who have transferred assets within the look back period are collected by counties when individuals apply for Medicaid, although they may not necessarily be collected, stored, or transferred to the state database in a systematic and standardized way. This can lead to gaps in the data available at the state level. Third, individuals may legally shelter or transfer their assets — and this analysis does not capture the total amount of assets transferred by persons who legally transfer assets but eventually use Medicaid to fund their nursing facility services.

Another shortcoming of the data is that spend-down amounts were available for only 20 counties. It was unclear why spend-down was recorded in some counties but not in others. It could be that people in these counties have more medical expenses, or that administrative practices regarding Medicaid eligibility determinations are done differently in each county. Alternatively it could have been caused by discrepancies in data collection, storage, and transfer at the county level. These 20 counties represented only 35 percent of the 57 counties included in this report, and may not be representative of the overall spend-down in the state. Further, spend-down patterns in the New York City area may be very different than the rest of the state.

No clear pattern emerged from comparisons of asset transfer denial data across counties, so such comparisons have not yet provided clues about the likely causes of higher asset transfer denial rates. For example, it was hypothesized that counties with higher per capita income levels might show higher asset transfer rates and higher subsequent denials, as people in these counties may have more assets to divest.

Alternatively, counties with higher per capita incomes might have lower asset transfer denial rates. For example, residents in affluent counties may more easily afford legal assistance to help divest assets and thus avoid detection. However, no clear association was found between asset transfer denial rates and county per capita income or county poverty rates, so neither hypothesis is supported by these data.

It is possible that the differences across counties are not due to real differences in asset transfers. The variations are large and may not be related to the clients. It seems reasonable that something else is generating the differences. For instance, the wide variation in asset transfer denial rates in different counties might reflect differences in administration. Perhaps some counties are more aggressive in investigating cases of asset transfers and enforcing eligibility regulations than others. However, because there are no measures of differences in county administrative activities, it is impossible to test these or related hypotheses about the effects of administration on reported asset transfer denial rates.

In the absence of a standard regarding how many elderly transfer assets in New York or elsewhere, it is unclear whether a 7 percent asset transfer denial rate over a 10-year period is more or less than what policymakers might expect. Studies have estimated that the use of annuities to shelter assets could cost each state's Medicaid program an additional $4.5 million a year, on average. Other types of asset transfers may add to this estimated cost. As New York's Medicaid program is one of the largest in the country, $4.5 million a year may not be considered a substantial cost savings.[74]

Discussions with other states suggested that New York's Medicaid eligibility system for tracking asset transfer denials was comparatively more sophisticated. A careful and more extensive extraction of historic data from New York's WMS than was possible for this analysis might reveal more significant trends and patterns of asset transfer denials in the state. Theoretically, through the WMS, the state can track who was denied Medicaid eligibility and when, when they reapplied and whether they spent down, how much, and whether they were granted eligibility. Discussions with officials in the other six states revealed that like New York, they are trying to address the asset transfer issue by implementing changes in eligibility regulations required by DRA 2005.

The issue of asset transfer is complicated. Researchers have varied views on how this practice impacts Medicaid long-term care, whether it increases costs substantially, the extent of its prevalence, what is a tolerable level, and how states can address the problem. While some policymakers suggest that asset transfer is prevalent and burdens the program with additional costs, others believe that many elderly have few assets and will use what they have to pay for their own long-term care needs.

As future demand for long-term care increases with the aging of the baby boomers, determining methods for controlling long-term care costs will be important. Although this research concludes that the significance of the proportion of asset transfers in New York is hard to determine with the information available for this research, such transfers still are an unnecessary cost to the Medicaid program. This analysis is useful because it is the first to identify what data are available to analyze asset transfers, where there are gaps in the data, and what other research could be useful for learning more about asset transfers in New York State.

[74] $4.5 million is not considered "substantial" by the authors because New York's Medicaid program costs approximately $45 billion a year.

V. Recommendations for Further Research

Further research in the following areas could provide better information for policymakers. Research recommendations for the New York State Department of Health related to the asset transfer and spend-down issues in this analysis are listed below:

Research recommendations for immediate action:

- Research on how variation in program implementation and regulatory enforcement at the local level affects asset transfer denial rates in different counties would be useful in identifying problems with implementation. Investigate why certain counties have higher asset transfer denial rates and spend-down than others, and what factors contribute to such variation. Identifying causes of variance could point to areas where policy changes could minimize asset transfers. This research could be conducted by obtaining information from the state's local social service offices and contacting Medicaid eligibility workers in selected counties.
- The asset transfer analysis in this report is limited to areas outside of New York City. New York City's Medicaid system and related data on asset transfer are tracked separately than the rest of the state. Because the majority of Medicaid long-term care expenditures are in New York City, an analysis of these data could yield more comprehensive information to inform policy decisions and point to areas that warrant further research.

Research recommendations for future action:

- The state could consider researching ways to increase the use of private long-term care insurance. Qualitative data, such as interviews with county officials, focus group discussions with key stakeholders like the elderly, providers, elder law attorneys, private long-term care insurance companies, and local social services districts, could help determine ways to increase the purchase of private long-term care insurance.[75] The research might also involve examining how other states are attempting to increase long-term care insurance purchases. For example, are other states developing protections for consumers who buy long-term care insurance? Are they regulating the rate of insurance premium increases over time or ensuring that long-term care insurance can be used for a wide range of services? If so, residents may be more likely to buy it. Other states also may have information about how to effectively market private long-term care insurance or make insurance more affordable through subsidies, increasing the number of people purchasing insurance, or getting younger persons to buy long-term care insurance.[76]
- An analysis of spend-down patterns may help to better target marketing of private long-term care insurance. Spend-down patterns may indicate the need and/or demand for private long-term care insurance in different counties and help determine where better marketing is needed. It also may inform policies aiming to reduce voluntary impoverishment among the elderly by analyzing factors that contribute to and influence spend-down. A trend analysis of spend-down

[75] Connecticut conducted a similar study before starting their LTC partnership program.
[76] Strategies for affordability could be similar to those used in the regular health insurance market.

also may provide insight into future demand for programs like New York's long-term care partnership plan.

- DRA 2005 changes in asset transfer regulations were implemented in 2006. Analyzing DRA 2005 implementation after a five-year period (the new look back period) could help determine whether the provisions in the legislation have been effective at reducing asset transfers and saving the state money.
- In the absence of a systematic means to assess asset transfers using New York State's WMS data, consideration should be given to conducting further research by accessing health and retirement study (HRS) data from the University of Michigan.[77] These data have state-level information on assets held by elderly households (defined as having at least one member 65 years and older), and the extent and amount of money transferred. The data also have information on income and benefits of elderly persons, health characteristics of the elderly, and related information on skilled nursing facilities (SNFs) claims.

Recommendations for future research in related areas include:

- Evaluating the impact of New York's long-term care partnership program on reducing asset transfers could be helpful in determining its effectiveness. The research could include an evaluation of other states' experiences with partnership programs to determine if some appear more effective than others, and if so, what it is about those programs that makes them more successful at reducing dependence on Medicaid as a funding source for long-term care.
- New York's large population of elderly poor should be investigated to determine what effect, if any, this group may have on the state's Medicaid long-term care spending. This analysis could be done separately for New York City and the rest of the state. A multivariate regression analysis involving demographic (age, gender, race), geographic (county of residence), economic (income, employment, assets), and supply factors (concentration of nursing facilities, availability of home health care) might be useful in determining whether high poverty rates among elderly New Yorkers significantly predict the state's high Medicaid long-term care spending.

[77] The University of Michigan Health and Retirement Study (HRS) surveys more than 22,000 Americans over the age of 50 every two years. Supported by the National Institute on Aging (NIA U01AG009740), the study provides information on America's aging population and its physical and mental health, insurance coverage, financial status, family support systems, labor market status, and retirement planning.

Appendices

Appendix 1: Details about the Data

New York State Department of Health (NYSDOH) Data

This report examined the New York State Office of Health Insurance Program's (OHIP) Medicaid Client Notice System (CNS), which sends out denial notices to people who are ineligible for Medicaid coverage due to excess income or resources. The Department of Health's Medicaid Automated Budgeting and Eligibility Logic (MABEL) data and the Office of Temporary and Disability Assistance's (OTDA) Welfare Management System (WMS) Medicaid nursing facility services denial data also were explored

Client Notice System Codes

The Client Notice System (CNS) is a computer subsystem of the WMS that generates notices for clients in different public assistance programs related to their beneficiary status. OHIP uses CNS to generate client notices for Medicaid applicants and enrollees to inform them of acceptances, denials, and status changes. There is a separate CNS unit for the New York City region (Bronx, Kings, New York, Queens, and Richmond counties) for generating Medicaid notices, and a CNS unit at OTDA that handles notices regarding temporary assistance and food stamps. This report refers to OHIP's CNS unit.

To estimate the incidence of asset transfer in the state, Rockefeller Institute staff, with assistance from the OHIP, reviewed the CNS, which uses approximately 500 codes to generate notices for Medicaid applicants and enrollees. These notices inform them of an action that has been or will be taken, or an action that they must take to become eligible for Medicaid. The CNS creates notices using language specific to the "reason code," which includes data from the WMS case record, Client Identification Number (CIN), MABEL budget record, and data supplied by the Medicaid worker.[78] A CNS notice also may contain attachments and inserts that provide information about initiating a fair hearing in the event that a client believes his or her case has been incorrectly determined. Additionally, the notice provides information about regulation citations, voter registration, available Medicaid programs, Health Insurance Portability and Accountability Act (HIPAA) privacy, and Medicaid law. Specific codes are listed on code cards and language associated with each code is available to local department of social services personnel.

Creating notices involves several steps. The language used in the notices is first derived from policy. OHIP's CNS unit then reviews the language, assigns a reason code, and writes applicable system specifications. These specifications are then submitted to CNS computer programmers. Finally, the CNS unit tests all notices and informs local districts (counties) of the changes through a WMS/CNS coordinator letter, which precedes each migration (transition from one status to another such as from "opened" to "denied" or "closed" or from "denied" to "open," etc.). Local district workers apply CNS codes to each case to prompt the system to send a notice to the applicant.

[78] Reason code: Codes for why a certain action is being taken on a Medicaid applicant/recipient. Source: OHIP.

The CNS case level notices have codes (usually referred to as "case codes") for the following categories:

1. Openings: Some or all cases are being opened or reopened.
2. Denials: All individuals are being denied.
3. Discontinuance: All individuals on a case are being closed.
4. Open/Close: All individuals on a case will be opened for a specified period of time.
5. Undercare: At least one individual on the case must remain active.

Status codes represent the current status of the applicants. There are 13 different CNS status codes: applying, withdrawn, active, inactive-excess resource inc/non-applying HH member (PA only), not applying, inactive-sanctioned, rejected/denied, deceased, removed/deleted, administrative suspense, single use, incarcerated individuals with suspended Medicaid coverage, and closed. Five status codes were selected for this analysis: active, inactive-excess resource inc/non-applying HH member (PA only), rejected/denied, deceased, and closed.[79]

At the individual level, CNS reason codes apply to specific individuals; there can be up to three individual reason codes for each person. CNS codes for all counties, excluding the five in New York City, were reviewed for this analysis.

Medicaid Coverage Codes

Rockefeller Institute staff also examined Medicaid coverage codes. OHIP staff identified "MA10" as a Medicaid coverage code that is used for individuals who have transferred assets. The kind of coverage a recipient receives depends largely on their individual circumstances. Income and resources of the applicants, along with household composition and other criteria, are taken into account when determining Medicaid eligibility. DOH staff indicated that MA10 represents "All Services Except Nursing Facility Services," and is used to allow Medicaid coverage (but not coverage for nursing facility services) to eligible recipients who have transferred assets. Under this code, the state provides Medicaid assistance to eligible applicants, but restricts the coverage of nursing facility services.[80]

State Comparison Data

Officials in seven states, including New York, were interviewed by telephone to assess the availability of asset transfer information among the elderly. The states contacted were California, Connecticut, Florida, New Jersey, New York, Pennsylvania, and Washington.

Other Secondary Data

Secondary sources also were explored for this analysis. Population data were reviewed from the U.S. Census Bureau and the New York State Data Center, and New York State Department of Health Medicaid enrollment and expenditure data were examined.

[79] HH: home health; PA only: public assistance only.

[80] Source: OHIP. Note: Nursing facility services may include alternate care in a hospital, nursing home hospice services, intermediate care facility services, nursing home care, and nursing home managed long-term care.

Appendix 2: Medicaid Status Codes

Status Codes	Description
1	Applying
6	Withdrawn
7	ACTIVE
8	Inactive – Excess Res Inc/Non-Applying HH Member (PA Only)
9	Not Applying
10	Inactive – Sanctioned
11	Rejected/Denied
13	Deceased
15	Removed/Deleted
16	Administrative Suspense
17	Single Issue
19	Incarcerated Individual with Suspended MA Coverage
20	Closed

Source: NYSDOH Office of Health Insurance Programs; extracted from the WMS.

Appendix 3: Medicaid Coverage Code Descriptions

CODES	COVERAGE CODE DESCRIPTIONS	MEDICAID COVERAGE TYPE
A 01	FULL COVERAGE (FUL-COVR)	Coverage for all Medicaid covered services/supplies.
B 10	ALL SERVICES (AS-NOLTC) EXCEPT NURSING FACILITY SERVICES	Coverage for all Medicaid covered services/supplies except long-term care services (i.e., intermediate care facility (ICF) and waiver services).
C 02	OUTPATIENT COVERAGE (OPAT-COV)	Coverage for outpatient care only. No coverage for hospital, ICF or nursing home room & care. Allows payment of short term nursing home rehabilitation.
D 09	MEDICARE CO-INSURANCE & DEDUCTIBLE ONLY (MED-CDO)	Coverage for Medicare deductibles and co-insurance amounts for Medicare approved services. No coverage for Medical services/supplies
E 07	EMERGENCY SERVICES ONLY (EMER-SER)	Coverage for medical services/supplies related to the medical emergency only.
F 18	FAMILY PLANNING SERVICES ONLY (FAM-PL)	Coverage for family planning services only.
G 31	PCP COVERAGE ONLY (PCP-CV-O)	Coverage for managed care premiums only. The prepaid capitation program (PCP) provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for Medicaid services. No coverage for medical services/supplies.
H 08	PRESUMPTIVE ELIGIBILITY HOME CARE (PR-EL-HC)	Coverage for medical services except hospital based clinic, hospital emergency room, hospital inpatient, and residential health care services.
I 13	PRESUMPTIVE ELIGIBILITY PRENATAL CARE A (PE-PC-A)	Coverage for medical services except inpatient care, institutional long-term care, alternate level of care, and long-term home health care.
J 14	PRESUMPTIVE ELIGIBILITY PRENATAL CARE B (PE-PC-B)	Coverage for ambulatory prenatal care services excluding inpatient hospital, long-term care, hospice, alternate level care, ophthalmic services, durable medical equipment (DME), speech, physical, and outpatient therapy, abortion services, and podiatry.
K 05	SANCTIONED (SANCT)	
L 15	PERINATAL CARE (PRNTLCAR)	Coverage for a limited package of benefits excluding podiatry, long-term home health care, long-term care, hospice, ophthalmic services, DME, therapy (speech, physical, and outpatient), abortion services, and alternate level of care.
N 04	NO COVERAGE – INELIGIBLE (N-COV)	Not covered for Medicaid services.
O 17	HEALTH INSURANCE PREMIUM (HIP-ONLY)	Coverage for health insurance premiums only.
P 30	PCP FULL COVERAGE (Managed Care) (PCP-F-CV)	Coverage under a prepaid capitation program (PCP). The client is PCP eligible, as well as eligible for limited fee-for-service benefits.
Q 32	PCP/SAFETY NET (PCP-HR)	Safety net recipient covered under a PCP. The client is PCP eligible, as well as eligible for limited fee-for-service benefits.
R 33	PCP GUARANTEE/SAFETY NET (PCP-G-HR)	Safety net recipient coverage for managed care premiums only. The PCP provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for Medicaid services. No coverage for out of plan medical services/supplies.
T 16	SAFETY NET (HR-COV) Historic Only	Coverage for all Medicaid covered services/supplies.
U 34	FAMILY HEALTH PLUS (FHP-P)	Covered under comprehensive benefits package provided through managed care organizations for adults with and without children who have incomes or assets greater than the current Medicaid standards.
V 06	PROVISIONAL-EXCESS INCOME (PROVSNL)	Not covered for Medicaid services until a spend-down of excess income/resources is met.
W 36	FAMILY HEALTH PLUS (FHP-CC)	Coverage for Family Health Plus (FHP) premiums only. The FHP plan provider is guaranteed the capitation rate for a period of time after the client becomes ineligible for FHP services. No coverage for out of plan medical services/supplies.

Sources: New York State Office of Health Insurance Programs; eMedNY; and WMS.

Appendix 4: Medicaid Case Reason Code Descriptions

Case Reason Codes	Description
162	Current Assets Exceed Allowable Amount
201	Excess Income (CT 19)
202	Excess Income
205	Excess Resources (Includes Lump Sum Payments)
206	Excess Resources (Includes Lump Sum Payments)
252	Too Much Money in the Bank
290	Transferred Property for Purpose of Qualifying for Assistance
320	Recalculation of Budget Shows Sufficient Income
410	Excess Income (Financially Ineligible for Services)
791	Lump Sum Not Eligible for MA
842	Transferred Assets to Become Medicaid Eligible
937	Receipt of or Increase in Earned Income as a Result of Other Unearned Income
973	Change in Amount of Excess Income – Medical Bills May Equal or Exceed the Excess
B52	B52 Spend down to MBI-WPD
B53	B53 Spend down to MBI-WPD
B54	Budget-Spend down – Decrease In Excess Income
C20	Discontinue MA
C22	Acceptance
C24	Acceptance
C26	Chronic Care without Long-Term Care (LTC) to Chronic Care with Community Based Care.
E30	Excess Earned Income – No TMA
E31	Excess Income – Increased Earnings – TMA Eligible
E32	Excess Income – Increased Support Collection – MA Extension
E33	Excess Income – Increased Earnings – TMA Guaranteed
E34	Excess Income – Receipt of SSI Single Individual
E35	Excess Unearned Income – No TMA
E36	Excess Income – Increased Support Collection – No MA Extension
E37	Excess Income
E38	Excess Income – Lump Sum
E39	Excess Income – COLA
E40	Excess Income – Budgeting Error
F33	Excess Income – Deemed Income of Alien Sponsor (CT 11)
F34	Excess Income – Section 8 – Lower Standard Of Need
F37	Excess Income – FS Disaster Area
F38	Excess Income – Lump Sum (No MA Ext.)
F49	Excess Resources – FS Disaster Area
F59	Excess Resources
F69	Excess Income and Resources
G40	Excess Income – Budgeting Error
M33	Excess Income – Deemed Income of Alien Sponsor (CT 11) (HH>1)
M34	Excess Income – Including Striker's Income
M35	Lump Sum – No Good Reason Provided
M37	Lump Sum – Shortened Ineligibility Period
Q0	Recovery
Q1	Recovery
S74	Accept
S75	Accept instit indiv limited coverage due to prohib transfer exc res sd met
S76	Accept
S77	Accept
S78	Accept
S79	Accept
S82	Community Coverage with No LTC
S83	Accept Inst Indiv

S84	Accept inst indiv
S85	Accept Community Coverage with Community Based LTC
U12	MBA-WPD to MA Excess income
U18	U18 Disc MBI-WPD Excess Income and/or Resources #
U19	U19 Deny MBI-WPD Excess Income and/or Resources #
U28	MBI-WPD To Excess Income
U29	MBI-WPD to Excess Income
U30	MBI-WPD to Spend down Not Met
U31	FNP Parents Discontinuance Over Income and/or Resources
U32	Discontinuance – Excess Income
U33	MA Excess Income Turning 19
U40	Excess Resources
U41	Transfer of Resources (CT 12)
U42	Excess Resources – Refused to Sell Property
U43	Excess Resources – End of 6 Month Period
U44	Excess Resources – Deemed Resources of Alien Sponsor (CT 11) (HH>1)
U45	Excess Resources -– Increased Resources
U48	Excess Income and Resources – Child Turning 6
U49	Excess Income – Child Turning 1
U50	Excess Income and Resources – Child Turning 1
U51	Denial
U52	Denial
U53	Transfer of Resources
U54	Closing
U55	Excess Income
U56	Excess Income and Resources
U59	Discontinuance – Excess Income and Resources
U94	Turning 65 FHP to MA with Excess Income and Resources
U96	Turning 65 FHP to MA with Excess Resources
U97	Opened in Error – Excess Resources
V91	Added
WFT	Added
WHT	Added
WJT	Added
WPT	Added
WRT	Added
WST	Added
X10	Excess Income
X12	Spousal Impoverishment – Failure to Execute an Assignment of Support
X13	Spousal Impoverishment – Excess Resources
X76	Decrease in Excess Income Amount
E95	Dead

Source: New York State Office of Health Insurance Programs; extracted from CNS.

Appendix 5: Methods of Tracking and Storing Asset Transfer Information from People Who Applied for Medicaid in 2008

States	Whether and How the States Tracked Asset Transfers
California	Asset transfers are not tracked, but estate recovery program staff have some knowledge about assets once they engage in recovery efforts. County level enrollment workers also have some idea about the applicants' assets, but they do not formally track it or keep any information in the system.
Connecticut	The state does not track asset transfers systematically over time, only checks information related to eligibility.
Florida	The overall Medicaid eligibility determination process is captured in a system called the Florida system. It sends out notices about penalty periods, etc. This is similar to New York's Client Notice System (CNS).
New Jersey	There is no systematic asset transfer tracking. There is some tracking of eligibility terminations at the county level, but no denial tracking. The state has information on when Medicaid services were terminated for individuals, but no information on when, why, or how many times an application was denied.
New York	The state has a system where denial notices are sent to those who do not qualify for Medicaid due to excess income or assets. The overall Medicaid eligibility determination process is captured in the Welfare Management System (WMS).
Pennsylvania	The state has no way of systematically tracking denials or asset transfers.
Washington	Asset transfers are tracked informally through a client denial notice system. Regional program managers have been sending copies of client denial notices to the state office since the implementation of DRA 2005.
	Where Information Regarding Asset Transfer Is Most Likely to be Found
California	The state officials contacted were not sure where this information could be found, if at all.
Connecticut	The Department of Social Services asks applicants at the initial point of contact about their income and assets.
Florida	The eligibility system is managed by the Department of Children and Families' Access Program Office.
New Jersey	Some information regarding assets and income may be found at the county welfare agency. However, the state officials who were interviewed were not certain.
New York	Information is in the WMS within the Office of Temporary Disability Assistance (OTDA). Some information is housed with the Office of Health Insurance Programs (OHIP) within the Department of Health and some information may be available at the county level.
Pennsylvania	The state does not track asset transfers, so state officials were not sure where this information might be found.
Washington	The Department of Social and Health Services Division of Aging and Disability Services oversees long-term care and services for the aged, blind, and developmentally disabled populations.
	How Asset Transfer Information is Stored
California	Information is not stored electronically or tracked systematically by any agency/department.
Connecticut	Information is not stored electronically or tracked systematically by any agency/department.
Florida	The eligibility system is a state electronic system, but the actual processing is done at the county level.
New Jersey	The information is not systematically tracked or stored.
New York	The state does not formally track asset transfers. Other information is stored electronically in the WMS and by paper at the county level.
Pennsylvania	Information is not stored electronically or tracked systematically by any agency/department.
Washington	Informal tracking occurs and information is stored either in paper files or in electronic format.

Source: HPRC staff phone interviews with officials of selected states.