

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**VULNERABILITIES IN MEDICAID ASSET  
VERIFICATION**



**JUNE GIBBS BROWN**  
Inspector General

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OEL-07-92-00882

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To obtain a copy of this report, call the Kansas City Regional Office at (816) 426-3697.

# EXECUTIVE SUMMARY

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## PURPOSE

To describe States' Medicaid long term care eligibility systems, asset verification processes and their fraud referral techniques, and identify potential vulnerabilities in these systems.

## BACKGROUND

Within the Health Care Financing Administration (HCFA) guidelines, each State has its own Medicaid rules and provisions governing Medicaid long term care eligibility. The States submit a State Plan that, when approved by HCFA, provides the basis for payment of Federal funds to cover at least half of the expenditures incurred by the State in providing medical assistance and administering programs.

Medicaid coverage of long term care costs is based upon a needs test where an individual has limited assets. Some individuals may be motivated to transfer their assets to other family members to avoid the requirement to use them to finance their long term care expenses.

To determine what States are doing to determine eligibility and detect fraud regarding assets, we conducted a mail survey of the 50 State Medicaid agencies in late 1993. We also selected five States in the spring of 1994 to visit based on information and materials received from the mail survey and our analysis of that information. At these States we interviewed Medicaid policy staff and State fraud investigators to supplement information from the surveys.

## FINDINGS

### **Most States Rely Only on Readily Available Sources for Asset Verification**

We found nearly all States verify checking and savings accounts, pay stubs and insurance policies of the Medicaid long term care applicant, but States vary on requesting income tax returns and other types of financial information. Medicaid eligibility staff allege they do not have adequate time to effectively ascertain the extent of all potential assets of Medicaid applicants.

Thirty of 50 States have Medicaid fraud hotlines. Although most States do not routinely check applications against hot line complaints, half the States who have them believe that they may facilitate an initial investigation to verify the validity of a possible transfer or concealment.

Thirty-eight States have specific Medicaid long term care fraud penalties for the non-reporting of resources. In general, we found that prosecution of medical assistance

fraud is a low priority for States, and that Medicaid applicant/beneficiary fraud is identified in less than 1 percent of cases. This is due to consideration of the applicant's age, the difficulty of proving intent, and the low dollar amounts involved.

### **HCFA Has Worked in Partnership with State Medicaid Agencies to Improve Asset Verification**

The HCFA has assisted States in improving asset verification. The HCFA has actively monitored States' activities and progress in identifying assets and sharing best practices of asset verification.

### **RECOMMENDATIONS**

HCFA should continue to work in partnership with States to promote:

#### **Comprehensive Asset Verification Techniques**

States should enhance investigative skills and request more detailed applicant information. Information which paints an inconsistent picture of the applicant's financial past or which appears questionable, should be investigated further.

#### **Identification and Sharing of Useful Best Practices among States**

HCFA should continue to promote the sharing of technical assistance among States, especially asset verification processes, fraud identification techniques, and other effective procedures that have proven to be predictable and reliable indicators for States in identifying undisclosed, concealed or transferred assets.

### **AGENCY COMMENTS**

The HCFA concurs with our recommendations to promote better asset verification among State Medicaid agencies. At the same time, the agency notes the limitations of the study, including lack of information on what practices are most effective, limited discussion of the Income Eligibility Verification System, and timing of data collection. We generally agree with HCFA's comments. Our goal was to obtain a preliminary description of what States were doing to come to grips with what is essentially a very complex administrative problem. It seems to us, though, that some States were doing more than others and that they could well learn from one another how to approach this situation. The HCFA also provides suggestions and ideas about practical problems that are likely to be encountered in implementing the recommendations. We encourage the reader to carefully review all of HCFA's comments which are included in their entirety in Appendix A. We have made several revisions to our report in response to them.

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# INTRODUCTION

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## PURPOSE

To describe States' Medicaid long term care eligibility systems, asset verification processes and their fraud referral techniques, and identify potential vulnerabilities in these systems.

## BACKGROUND

### *Eligibility for Medicaid Long Term Care*

Each State has its own Medicaid rules and provisions governing Medicaid long term care eligibility. These include the guidelines and limitations established by Part 430 of "Grants to States for Medical Assistance Programs" in Title XIX of the Social Security Act and implementing Medicaid eligibility regulations (42 Code of Federal Regulations 430).

Medicaid coverage of long term care is intended for those individuals with inadequate resources to provide for themselves. As such, persons with substantial assets are not eligible. However, in determining eligibility for Medicaid long term care, States may count only income and assets that are available to the applicant or beneficiary, i.e., those funds under the applicant's control. Certain assets and resources (which can often be of any value) are exempt, including the home (in many cases), burial policies, small savings accounts, and funds to maintain the spouse in the home. There is also a provision for coverage of persons with a higher dollar amount of assets who have incurred long term care expenses. Once these individuals have depleted their excess resources, they may qualify for Medicaid. In addition, they must also reduce their excess income each month in order to remain eligible.

Because of these rules, some individuals may be motivated to transfer their assets to other family members to avoid the requirement to use them to finance their long term care needs.

## METHODOLOGY

### *Mail Survey*

The inspection was conducted in two phases. In phase one, we conducted a mail survey of the 50 State Medicaid agencies. Topics addressed include eligibility policy, asset verification, Medicaid beneficiary fraud referrals, estate recoveries by type and amount, Medicaid liens, death and spousal information, and trusts and other influences on estate recovery. While the survey was comprised of many closed-ended questions, we also used some open-ended questions that provided more in-depth information to explain and expand upon close-ended responses.

The surveys were submitted to State Medicaid agencies in October 1993. We received our final State responses in late May 1994.

### *Five State Sample*

In phase two, we selected a judgmental sample of five States based on the information obtained from phase one. We chose Massachusetts, Minnesota, Missouri, Oregon and Wisconsin because of information completed on their surveys. We visited each State to conduct interviews with State Medicaid agency staff and State Medicaid fraud investigators. We used questionnaires to follow up on responses reported in the surveys.

### *Analysis*

The inspection team summarized and tabulated the responses to all the survey questions. The responses were quantified to determine such issues as how many State Medicaid agencies have eligibility verification programs to identify and prevent transfers of assets, the outcomes from these identification systems, how many States make Medicaid fraud referrals, what those referrals entail, and whether States have fraud penalties and hotlines.

### *Scope*

This report is one of two related national reports. An earlier companion report described States' efforts in implementing Medicaid long term care estate recovery programs.

We conducted our review in accordance with the *Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

# FINDINGS

## Most States Rely Only on Readily Available Sources for Asset Verification

We found that nearly all States verify checking and savings account amounts, pay stubs, and insurance policies of the Medicaid applicant. Most States also verify Certificates of Deposit, Individual Retirement Accounts and other investments by directly contacting banks and other financial institutions. Some States, however, use a variety of methods to verify financial information (See chart below for States' self-reported techniques.)

-Checking accounts	49 States
-Savings accounts	49 States
-Pay stubs	49 States
-Insurance policies	49 States
-Certificates of Deposit	48 States
-Individual Retirement Accounts	48 States
-Federal tax returns	24 States
-State tax returns	19 States
-Letters to banks/credit unions	15 States
-County assessor offices	13 States
-Caseworker's interviewing skills	5 States
-Rely on Medicaid Quality Control staff	3 States
-Families/friends of Medicaid applicant	3 States
-Supplemental Security Income	2 States
-Department of Motor Vehicles	2 States
-Nursing home personnel	1 State
-Probate court	1 State
-Personal injury lawsuit records	1 State

When inquiring why State techniques vary, a major reason given by Medicaid eligibility staff (often referred to as Medicaid caseworkers) was that workloads do not permit adequate time to effectively ascertain the extent of all potential assets of a Medicaid applicant. Types of hidden or unreported assets or resources include bank accounts, Certificates of Deposit, or stocks and other financial investments.

While there is a Federal mandate for States to implement and operate IEVS, whereby States are required to conduct computer matches with State and federal agencies to verify reported income and resource (asset) information, States vary in abilities and



commitment to match with all of the required data sources. States often do not use all of the data match information because of State perception of the ineffectiveness of some IEVS data matches and shrinking State budgets and resources. These findings corroborate our July 1994 report "*Reforms Are Needed in State Income and Eligibility Verification Systems*," OEI-06-92-00080. That report addresses issues with State IEVS and makes recommendations for improving the efficiency of the IEVS requirements. A Federal IEVS interagency work group is working with the OIG and States to implement these recommendations.

In addition, 44 States utilize the IRS tape match. Five of these States say that it's effective, 27 say that it's somewhat effective or of limited value, while 9 States say it's ineffective. Three States did not respond. At least one-fourth of the States report that the information is too old to be useful.

Thirty States have Medicaid or general fraud hotlines at the State or county level which individuals may call to report an applicant who may have transferred, hidden or sheltered assets. Although only two States routinely check applications against hotline complaints, these hotlines may facilitate an initial investigation to verify the validity of a possible transfer or concealment. Almost one-half of the States said that leads and tips from relatives or neighbors are sometimes effective in discovering unreported property or assets of a Medicaid long term care applicant.

State Medicaid applications usually have a generic fraud statement explaining possible penalties for intentional concealment or misreporting of resources. An example is shown below.

*"Section 1128 of the Social Security Act (as amended by Public Law 100-93) provides Federal penalties for fraudulent acts and false reporting in connection with my application for or receipt of Medicaid benefits. I may be prosecuted in Federal Court for deliberate statements which I know to be false and which affect my eligibility for any benefit or payment under the Medicaid program. I may also be prosecuted for concealing or failing to disclose any event of which I have knowledge which affects my right to any benefit or payment..."*

Caseworkers explain penalty provisions during the standard applicant interview process. Thirty-eight States have Medicaid long term care fraud penalties for the non-reporting of resources; 12 do not. All States have general statutory penalties for theft.

Prosecution of medical assistance fraud on the part of the applicant/beneficiary occurs in less than one percent of cases. During our onsite visits, we learned that prosecuting a Medicaid beneficiary's fraudulent activity is a very low priority. This is due in part to consideration of the applicant's age, the difficulty of proving intent, and the low dollar amounts involved.

## **HCFA Has Worked in Partnership with State Medicaid Agencies to Improve Asset Verification**

The HCFA has taken responsibility to assist States in improving asset verification. In November 1994, HCFA released a resource guide for States in collaboration with the American Public Welfare Association. The HCFA has also conducted numerous training conferences with Medicaid State representatives.

The HCFA has actively monitored States' activities and progress in identifying assets and improving asset verification. The HCFA plans to continue to survey States and identify and share best practices of asset verification.

# RECOMMENDATIONS

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HCFA should continue to work in partnership with States to promote:

## **Comprehensive Asset Verification Techniques**

Although most States verify checking and savings account information, some States are not going beyond this basic analysis. States should enhance investigative skills and request more detailed applicant information. For example, Departments of Motor Vehicles, employer identification numbers, Veteran's Affairs offices and other local avenues are excellent resources.

During the intake process, eligibility staff should always ask long term care applicants about the existence of any trusts, annuities, burial policies, funeral plans and business partnerships. Gathering a more comprehensive synopsis of an applicant's financial background is beneficial. Information which paints an inconsistent picture of the applicant's financial past or which appears questionable should be investigated further.

## **Identification and Sharing of Useful Best Practices Among States**

HCFA should continue to promote the sharing of technical assistance among States, especially asset verification processes, fraud identification techniques, and other effective procedures that have proven to be predictable and reliable indicators for States in identifying undisclosed, concealed, or transferred assets.

Asset verification, at its best, should be exhaustive. The process of identifying possible hidden or illegal transfers of assets is a critical step in preventing Medicaid long term care eligibility fraud. Although asset verification can be an arduous task for Medicaid caseworkers, it is an essential part of the eligibility process that should not be overlooked.

The HCFA should ensure that States utilize the most efficient and practical methods when performing asset verification. To uncover undisclosed, concealed or transferred assets requires considerable attention to minute details of a Medicaid applicant's financial and property holdings.

## **AGENCY COMMENTS**

The HCFA concurs with our recommendations to promote better asset verification among State Medicaid agencies. At the same time, the agency notes the limitations of the study, including lack of information on what practices are most effective, limited discussion of the Income Eligibility Verification System, and timing of data collection.

We generally agree with HCFA's comments. Our goal was to obtain a preliminary description of what States were doing to come to grips with what is essentially a very complex administrative problem. It seems to us, though, that some States were doing more than others and that they could well learn from one another how to approach this situation. The HCFA also provides suggestions and ideas about practical problems that are likely to be encountered in implementing the recommendations. We encourage the reader to carefully review all of HCFA's comments which are included in their entirety in Appendix A. We have made several revisions to our report in response to them.

# APPENDIX A

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## AGENCY COMMENTS



Office of the Administrator  
Washington, D.C. 20201

DATE AUG 1 1995

FROM Bruce C. Vladeck *Bruce Vladeck*  
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Vulnerabilities in  
Medicaid Asset Verification," (OEI-07-92-00882)

TO June Gibbs Brown  
Inspector General

We reviewed the above-referenced report which describes States' Medicaid long-term care eligibility systems, asset verification processes and their fraud referral techniques, and identifies potential vulnerabilities in these systems. Attached are our comments on the report findings.

Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA)  
on Office of Inspector General (OIG)  
Draft Report: "Vulnerabilities in Medicaid Asset Verification."  
(OEI-07-92-00882)

OIG Recommendation

HCFA should continue to work in partnership with States to promote comprehensive asset verification techniques; establishment of Medicaid fraud hotlines and penalties; and identification and sharing of useful best practices among States.

HCFA Response

We concur with the report recommendation as it offers very basic suggestions for improving the efficiency of State Medicaid programs.

HCFA has continued to work with States to encourage asset verification by pointing out that good verification at the time of Medicaid application results in Medicaid coverage for those who are truly eligible. In addition, some asset verification is required by legislation such as the Income and Eligibility Verification System (IEVS) which requires States to conduct matches with the Internal Revenue Service (IRS), the Social Security Administration (SSA), and State wage and unemployment compensation agencies.

Even with Federal mandates for asset verification, when State budgets and staffs are shrinking, States often cut corners in the eligibility verification process. For example, if a State conducts IEVS matches, but fails to verify the leads identified in the match, an incorrect eligibility determination could result. Another obstacle to resource verification is that Federal regulations require that States process a Medicaid application within 45 days. Bank verification often takes more than 45 days so States will often put the applicant on the Medicaid rolls at the end of 45 days and not utilize the bank's information when it arrives. Many States also limit the number of asset verifications because financial institutions require reimbursement.

Data based on Medicaid Eligibility Quality Control reviews indicate that incorrect resource development continues to be the major cause of dollar error. However, the number of transfers of resource case errors that effect the error rates is very small. So, while transfer cases continue to be a slight problem, they do not significantly effect the total number of resource errors.

We also note that one of the most effective techniques for asset verification of applicants for long-term care is the use of eligibility staff who specialize in long-term care cases. Some States find it very cost-effective to provide special training and even higher salaries for workers who can become knowledgeable about the kinds of assets likely to be owned but not reported by long-term care applicants.

In general, the report fails to distinguish between two distinct aspects of the Medicaid program: State asset verification activities, which affect all Medicaid applicants/recipients; and asset policies affecting only persons seeking Medicaid for their long-term care expenses (specifically, rules regarding uncompensated transfers of assets and recoveries from estates of deceased long-term care recipients).

Activities that the report recommends for all States -- establishing Medicaid fraud hotlines, and more extensive data matching with other information sources -- typically apply across the board, not just to persons seeking assistance for long-term care. The recommendations are not persuasive because they are not accompanied by any detailed descriptions beyond the number of States that use the techniques, nor is any evidence given as to the effectiveness for either all Medicaid applicants or the subset of people seeking long-term care assistance. In fact, the report notes that while three in five States have a fraud hotline (page 4), only two States identified hotlines as a source that they actually use (page 3), strongly suggesting that hotlines are not very effective. If, on the other hand, hotlines are inexpensive, they may nevertheless be cost-effective even if they provide leads in just a few cases. If this is the case, the report would be more effective by saying so.

The report also recommends that HCFA work to ensure that all States establish penalties for false reporting in connection with a Medicaid application. We note several problems with this recommendation. First, the statutory citation provided in the report is no longer valid. Section 1909 was amended and redesignated as section 1128 of the Social Security Act by Public Law 100-93, the 1987 antifraud amendments. Second, this statute provides for Federal prosecution of people who misrepresent information about themselves. State penalties are permitted at the option of the State but only to persons who have been convicted under these provisions. Nothing in this language suggests that such penalties may be applied only against long-term care applicants. Third, as the report notes, such cases are seldom pursued because of the expense of prosecution relative to the dollars involved. The report should note whether the States that have such penalties think they are worth having because of the deterrent effect. Finally, the report would be clearer if it included a brief description of how fraud penalties and Medicaid rules on transferred assets and estate recoveries differ from, and complement, each other.

Finally, we note that the survey of States was conducted shortly after the effective date of the Omnibus Budget Reconciliation Act of 1993 provisions effecting transfers of assets and estate recoveries. This causes us to question whether State responses from this unstable, transitional period of time accurately reflect today's circumstances.



Technical Comments

Page i - Background - This section includes a synopsis of the procedures for transferring assets in order to meet the Medicaid income and resource requirements. However, the synopsis fails to point out that individuals who transfer assets for less than fair market value may be subject to certain penalties in the form of denied Medicaid coverage for a certain period of time (i.e., a penalty period).

The penalty period is determined by first ensuring that the transfer of assets for less than fair market value took place within the look-back period. The look-back period is the period of time during which a penalty for transferring assets for less than fair market value can be assessed and can range from 36 to 60 months. Penalties cannot be assessed for transfers taking place before this period.

Provided a transfer of assets took place during an individual's look-back period, a penalty period is calculated by taking the value of all assets transferred for less than fair market value and dividing it by the average monthly cost to a private patient for care in a nursing facility in the State.

The above comment also applies to the background section on page 1.

Page ii - Last Finding - There should be a reference in this section to the Federal mandate for States to use IEVS for verifying reported assets. Suggested language:

While there is a Federal mandate for States to implement and operate Income and Eligibility Verification Systems (IEVS), whereby States are required to conduct computer matches with State and Federal agencies to verify reported income and resource (asset) information, States vary in abilities and commitment to match with all of the required data sources. States often do not use all of the data match information because of State perception of the effectiveness of the IEVS data matches and shrinking State budgets and resources. An earlier OIG report, released in July 1994, addresses the issues with State IEVS and makes recommendations for improving the efficiency of the IEVS requirements. A Federal IEVS interagency work group is working with the OIG and States to implement these recommendations.

Page ii - First Recommendation - There should be a reference to the Federal requirement to conduct data matches under the IEVS requirements. It should be stressed that States have the flexibility to design IEVS to target, or selectively use, the most productive leads for identifying unreported assets.

Page 1 - Income Verification - This section is misleading because it seems to indicate that a State IEVS is for the purpose of identifying beneficiary fraud rather than a tool to assist States in making more accurate eligibility determinations for all categories of applicants and recipients of benefit assistance programs. The requirement that a beneficiary be terminated from receiving assistance if he/she fails to report all income and/or resources is a very broad requirement, and not one that is tied to the IEVS requirements. As with any violation of reporting assets/resources, if a beneficiary fails to report information, benefits will be terminated.

We also believe it would be helpful to include more detailed information about the IEVS, some of which is included in the July 1994 IEVS report. For example, States are required to match with SSA to obtain benefit information with the IRS for unearned income information, and with the State wage and unemployment agencies for wage and compensation information. Some of the data matches are indeed found to be more useful than others, particularly for different categories of beneficiaries. For example, the Aid to Families with Dependent Children program would find the wage and unemployment benefit data matches more effective, while the Medicaid program would find the IRS and SSA data matches more effective.

Through the targeting (selective use) option offered States in the IEVS regulations, States can focus the data matches to the most effective matches. While the IRS data might be a year old, it is often found useful as simply a "lead" to possible unearned income (bank accounts, dividends, real estate sales, etc.).

Further, the July 1994 IEVS report made recommendations for the Federal agencies responsible for the IEVS regulations to make adjustments to the requirements that would enhance State flexibility and efficiency of the IEVS.

Pages 3-4 - We agree that States' techniques vary widely for asset and resource verification because of workload constraints and priorities. States have to adjust workload priorities to address verification techniques that have proved to be effective. States have the experience and knowledge to base any priorities established to the most productive methods. States are given the flexibility by the Federal IEVS regulations to target followup efforts to the most productive sources. We strongly believe if States use the flexibility currently offered under the IEVS requirements to focus on productive followup information, more errors can be prevented.

States need to analyze and target the use of information obtained through the IEVS, particularly leads from the IRS and SSA for long-term care. Our contact with States, in the majority of cases, indicates these leads are useful and that States want more access to Federal data sources. The statements made on page 4 are too vague to be useful.

While there is some question about the usefulness of some of the IEVS data sources; e.g., the Beneficiary Earnings and Data Exchange with the SSA and the IRS data match for some categories of beneficiaries, other data matches are routine, required data matches for the States; e.g., the SSA benefit match and the wage and unemployment compensation matches.

This report seems to imply that States do not conduct routine data matches with the IEVS components. We do not believe that the findings and recommendations of the July 1994 OIG report on IEVS reflect this. Those findings and recommendations were directed to making the existing data match requirements more useful and efficient for States.

We also want to add that the IEVS interagency work group, with the Administration for Children and Families as the lead component, is currently working with the OIG and States in assessing the modifications needed to make the IEVS more cost-effective and efficient. The work group has also been working with five pilot States to access and analyze the usefulness of Veterans' Administration benefit data. States seem encouraged by the pilot results, and these data should be especially helpful for eligibility determinations for long-term care beneficiaries.