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Recently passed legislation will have New York State assume control of Medicaid administration and costs from counties. Administrative costs for Medicaid are estimated at $1.1 billion this year, with the state paying $221 million; New York City and the 57 counties, $330 million; and the federal government paying the remainder. State assumption of Medicaid administration and costs will be complicated, especially for eligibility determinations for persons in need of nursing home care. The complexity of the process contributes to variation among counties, as do other factors such as county capacity and complicated data systems. There are several areas where cost efficiencies could be achieved, although Medicaid benefits constitute a much larger share of costs than administration. Some of the cost savings from state assumption of Medicaid administration could take years to realize, and may not yield as much savings or consistency in the process as the state might anticipate. However, this paper highlights steps the state could take now to begin the process of centralization, as well as other ways to reduce costs both through administrative and policy changes.

HEALTH POLICY RESEARCH CENTER

Room for Interpretation

Causes of Variation in County Medicaid Asset Transfer Rates, Opportunities for Cost Reduction

August 2010

By Courtney Burke
With Barbara Stubblebine and Kelly Stengel

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I. Executive Summary

Legislation enacted as part of the 2010-2011 New York State budget requires the state health commissioner to develop a plan for state assumption of administrative responsibilities and costs for the Medicaid program from local social service districts. This paper examines Medicaid administration at the county level, in particular, determination of eligibility for Medicaid coverage of nursing home care.

This research was undertaken to further explore results from an analysis conducted by the Rockefeller Institute in 2009 that showed considerable variation among counties' rates of denial for Medicaid eligibility because an applicant had transferred assets. To determine why such variation existed, whether federal or state policies could be clearer to reduce variation, and whether there were savings that could be accrued from more consistent implementation of better administrative practices, the Rockefeller Institute undertook a second study.

The second study, the results of which are outlined in this paper, involved interviews with local officials in selected counties regarding eligibility procedures and other factors related to long-term care determinations. The study sought to identify differences in administrative processes that may account for differences in denial rates. The analysis compared counties that were similar in population and income but different in their rates of denial. This study found, however, that although administrative

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variation among counties was extensive, the differences were not clearly related to denial rates.

The interviews were helpful in illuminating many of the possible causes of variation in the Medicaid eligibility determination process for nursing home care:

- Approaches to collecting required eligibility-related paperwork may vary, since it can be a labor intensive process.
- Some counties accept a wider range of documents than others when processing applications.
- Counties use different codes in the Medicaid database to indicate when an individual has been denied eligibility due to asset transfer. Different codes are used, in large part, because many codes are repetitive and potentially ambiguous.
- County administrative capacity varies significantly, not only in terms of caseload, but also in terms of the stability and experience of the workforce.
- Counties use different standards for determining when they might investigate a questionable asset transfer. They also vary in their interpretations of assets' fair market value.
- Counties may benefit from more guidance regarding allowable services under what are known as "personal care contracts," as well as determining what qualifies as unusual circumstances surrounding asset transfers, but the state should also ensure that counties are in fact following the guidance provided by the state.
- Counties vary significantly in terms of where and from whom they receive nursing home care applications. Applications may come from individuals, or other entities on behalf of the individual, such as nursing homes, attorneys, or an applicant's representative.

This research also found differences among workers' approaches to the application process and levels of experience within the same county.

In addition to learning why there may be variation among counties' rates of denial for asset transfer, this study also sought to determine if there were opportunities for efficiencies, either through administrative or policy changes. Recommended administrative changes include:

- Centralizing the processing of nursing home eligibility redeterminations.
- Automating eligibility processes whenever possible by linking information in application documents with other databases that contain income and public program eligibility information.

Several of the recommendations regarding administrative changes could be instituted in the near-term, thereby immediately reducing costs for the state.

- Improving the process for obtaining asset information from financial institutions.
- Streamlining and clarifying uses of the state's Welfare Management System (WMS) coding system.
- Instituting a more efficient and effective quality assurance process.
- Ensuring consistency in policy enforcement when eligibility cases go to fair hearing.

There were a handful of other recommendations from counties about changing administrative processes, as well. All of these recommendations suggest where the costs and benefits of certain federal or state policies might be better assessed as the commissioner of Health examines how the state will assume control of Medicaid administration. Several of the recommendations regarding administrative changes could be instituted in the near-term, thereby immediately reducing costs for the state.

If the state's primary goal is to reduce overall costs, however, it should consider the fact that Medicaid benefits constitute a much larger share of Medicaid costs than administration. Therefore, the recommended changes to administration that are likely to have the most impact on costs are those that would impact benefits. These changes might include ensuring consistency in policy enforcement regarding eligibility for benefits when cases come to fair hearing, and ensuring an accurate quality assurance process to guarantee that only those who are truly eligible receive Medicaid benefits. In addition, state assumption of Medicaid administration must be implemented with careful attention to staffing and other efficiencies, so that costs are not simply shifted from one level of government to another.

Centralizing administration from 58 diverse local districts to one entity — New York State — could be achieved in different ways. Local offices might be closed, with all administrative staff located in Albany or in a handful of regional offices. Or, local government employees now administering Medicaid long-term care might remain in their home jurisdictions after the transition, with the state operating dozens of offices as it does with the state Labor Department's career centers. Or the state could centralize certain functions, such as mail-in applications or recertifications. Although the state may be able to decrease variation by centralizing certain functions, it may never be able to completely eliminate it since determinations can even vary among different workers within the same office. The analysis and recommendations in this report are intended to assist in consideration of a variety of potential administrative structures.

The study also produced some suggestions regarding federal policies — particularly, the extended "look-back" period relating to assets previously held by current Medicaid applicants. Some policies may produce results opposite to those intended. Some county officials believe that the increased complexity of the

application process for Medicaid nursing home services gives persons with excess income and assets more motivation to hire estate planning attorneys. Such attorneys can advise them on ways to legally transfer their assets so they never pay privately for the cost of their nursing home care. At the same time, lower-income persons with fewer assets may be more likely to be denied nursing home eligibility for transferring assets because they could not afford to hire an estate planning attorney. Thus, a policy aimed at reducing cost-shifting from more affluent families and individuals may hurt those of more modest means. All of these complexities are relevant to the state's plans to assume control of local Medicaid administration.

II. Background

Comprehensive 24-hour, skilled nursing facility care (nursing home care) is expensive. In parts of New York State, the cost may average over $100,000 a year.[1] Because of this high cost, individuals with moderate incomes can quickly diminish their resources paying for care. Once they have reduced their resources, including income and assets, to a low enough level, they may be eligible for Medicaid, a publicly financed health insurance program. Nationally, Medicaid funds nearly half of all nursing home costs, on average. In 2007, Medicaid paid for 46 percent of all nursing facility care ($57 billion out of a total of $123 billion).[2] In New York State, skilled nursing facility care cost $7.2 billion in 2008 and comprised 15.2 percent of all Medicaid spending.[3]

Overall Medicaid costs in New York are roughly $51 billion this year, with $1.1 billion of that amount attributable to administrative expenses. Of the latter costs, the state pays $221 million; New York City and the state's 57 counties, $330 million; and the federal government the remainder, according to the state Assembly.[4] In arguing for a state takeover of local administrative functions and costs, supporters said transferring administrative operations and expenses to the state level would streamline eligibility determinations while also reducing costs, potentially by hundreds of millions of dollars.

To avoid having to give away or sell all their personal assets to pay for nursing home care, some individuals attempt to shelter their assets in order to have Medicaid cover the cost of care. Individuals with excess resources may prospectively hire attorneys to help them determine how to legally shelter assets from being considered during the Medicaid eligibility determination process, should they need nursing home care. In 2006, Congress passed the Deficit Reduction Act of 2005 (DRA),[5] which included new regulations that make it more difficult for individuals to qualify for Medicaid to pay their nursing facility costs. The changes in DRA included lengthening the period of time that transferring assets (such as savings or stocks) could result in disqualifying an individual for Medicaid eligibility. Since 2006, all states have had to adjust to the new rules under DRA when making eligibility determinations for Medicaid nursing facility care.

Eligibility determinations for Medicaid long-term care services in New York State are highly decentralized. Medicaid eligibility for skilled nursing facility services is determined by 57 local departments of socials services (LDSS), plus New York City's Human Resources Administration (HRA). Because Medicaid is a significant expenditure for state and local governments, LDSS have sought to ensure that applicants who apply for Medicaid meet all eligibility requirements, including not having transferred assets as required under the DRA. LDSS in New York State must examine a wide range of an applicant's personal financial information in order to determine if asset transfers have occurred. Conceivably, the better job the LDSS does at ensuring accuracy in

eligibility determinations for expensive services like skilled nursing home care, the more costs that are saved in the Medicaid program. However, because the eligibility determination process is so complex, the extra administrative time required to investigate potential asset transfers may result in higher Medicaid administrative costs.

To better understand the issue of asset transfer, the Rockefeller Institute of Government conducted a study of existing state data in 2008-2009 that examined the approximate rate at which individuals applying for Medicaid were determined ineligible for nursing home care because they had transferred assets. The research used Medicaid coverage code "MA10" as a proxy for persons who had been denied Medicaid eligibility for nursing home services because of asset transfer. The analysis revealed evidence of large disparities among counties' estimated Medicaid eligibility denial rates for nursing home care.[6] For instance, although the rate of denial averaged around 7 percent over 10 years for all counties, some counties had rates near 50 percent, while others had rates of less than 1 percent.[7] Differences could not be explained by characteristics of the population in each county, such as the percent of the population over age 65 or the average per capita income.

This raised the following questions: Why would there be large disparities in denial rates because of asset transfers if counties are following the same federal and state policies regarding eligibility determinations? What could be learned about the causes of variation that might suggest where further clarification of administrative policies could be helpful? Are some counties using policies or practices that are more efficient? Are there areas where cost efficiencies could be achieved?

To help understand possible causes of variation among counties and to develop recommendations that might help reduce Medicaid costs, Rockefeller Institute staff undertook a second study in 2009-2010, the results of which are presented in this paper. The research involved reviewing numerous documents, such as administrative directives from the Department of Health and the WMS code book, and interviewing a variety of Medicaid staff in 16 counties and New York City. Interviews were also conducted with Medicaid estate planning attorneys, nursing home administrators (including a deputized eligibility worker), and one representative from a private company that assists hospital patients being discharged to nursing homes to complete appropriate Medicaid application processes. To enhance county participation in the research, individuals and officials are not identified in this report.

Such findings may be particularly timely because of legislation that passed in July 2010, as part of action on the 2010-2011 state budget, mandating that the commissioner of the New York State Department of Health "create and implement a plan for the state to assume the administrative responsibilities of the medical

assistance program performed by social service districts."[8] The law further requires the commissioner to establish a process for implementation over five years, starting April 1, 2011. The plan is to identify "operational objectives that create efficiency in administrative functions" and "standards that provide greater uniformity in eligibility criteria and continued enrollment." Other elements of the plan are to include "a definition of administrative services."[9]

Until such a definition is in place, it is uncertain whether the state will take over all Medicaid eligibility determinations currently managed by the 57 LDSS and New York City's HRA. This paper takes as a starting point, therefore, the possibility that counties may retain some role in such decisions — at least during the five-year phase-in period. Findings regarding potential cost efficiencies thus may interest state and local officials as they consider centralization of Medicaid administration.

III. Why Counties May Differ

There are several reasons why counties may differ in their administration of the Medicaid program. An initial analysis by the Rockefeller Institute sought to pair counties in a systematic way. Counties with similar demographics (population size, rate of poverty) but with differing rates of denial were paired and examined to determine if clear administrative differences existed. Table A in Appendix A outlines how counties were roughly paired and indicates whether any notable administrative variation was apparent from the field research. There were some differences. For instance, several counties used different dollar amounts as a trigger to investigate an asset transfer; some used different codes to classify denials for asset transfers within the Medicaid system; and some appeared to be more "consumer friendly" than others. However, the dollar amount at which an investigation into an asset transfer occurs, or the approach of the counties and the approximate rate of denials did not appear to be closely correlated, nor was there a clear correlation between the rate of denial and the use of different codes. Coding differences are explained in more detail in a later section of this paper. Overall, no significant patterns emerged that could tie rates of denial to tougher administrative practices.

The following sections explain in more detail some of the areas where differences were noted among counties and workers, based on Institute interviews and examinations of public documents. The fact that some differences exist is not surprising. Eligibility determinations for long-term care are complex and offer more room for interpretation than eligibility decisions involving populations applying for or enrolled in the general Medicaid program. Specific reasons why comparative analyses of the counties may be difficult are also discussed in this section.

Approaches to Collecting Required Paperwork

To explain the eligibility rules for Medicaid funded skilled nursing home care in the most simplistic way: an individual must have limited income and assets.[10] The amount of income and assets that individuals can have is set in state regulation, and it is the responsibility of local departments of social services to determine whether individuals meet the income and asset requirements.

The eligibility process generally works as follows: If an individual requests or needs Medicaid nursing home services, the LDSS must send an applicant the list of documents required for the eligibility determination process. Applicants then begin collecting the required documents. If they submit an application with missing documentation, they are notified in writing by the LDSS, and then have 10 days to submit the missing information, or must show that they are making attempts to collect it.[11] Because it may take individuals longer than 10 days to collect what

is needed for the application, they often are granted extensions by the LDSS. Once the individual submits all required paperwork, the LDSS has 45 days to make an eligibility determination.[12] Presumably, because the income and asset requirements are the same across the state, there should be little variation in rates of eligibility denials or in the time it takes to process applications.

But the Medicaid application process for nursing home services is much more complex than it is for other Medicaid eligibility categories because individuals must prove they have not transferred assets during the five years prior to the time of application. Examining whether persons have transferred assets during the previous five-year period, known as the "look-back period,"[13] requires collection of a wide range of documents. Accounts and resources that are subject to investigation include: checking and savings accounts, credit union accounts, certificates of deposit, retirement accounts, life insurance policies, annuities, stocks, bonds, mutual funds, trust accounts, burial assets or burial contracts, vehicles, home equity value, and any other real property (other than home) value.[14] Applicants who are institutionalized and applying for nursing home care coverage must also answer specific questions regarding asset transfers including, but not limited to, whether or not the applicant is changing ownership of real property, selling property, purchasing a life estate, or has transferred any assets into or out of a trust. Additionally, where applicable, applicants must provide copies of their own or their spouse's tax returns for the previous four years.[15]

The amount of paperwork collected by local departments of social services in New York State from Medicaid applicants seeking nursing home care was described during interviews with county officials as "a wheelbarrow full," "a 12-inch thick accordion binder," and "17 shoe boxes of documents."

For applicants, especially if they are frail and elderly, or are the spouse or family member of a frail elderly applicant, obtaining this paperwork can be arduous — so much so that when asked what percent of applicants are able to provide all of the correct documentation the first time they submitted an application, all of the counties interviewed for this study said anywhere from 90-100 percent of applications were incomplete. This is because there are so many documents that are required, and obtaining information about five years' worth of assets can be difficult.

When there is documentation missing from an application, it is required that the LDSS generate notices indicating what paperwork is outstanding. The LDSS must then assist the applicant in obtaining such information.[16] Missing paperwork requires counties to follow up with applicants, banks, or other institutions, sometimes repeatedly, to ensure all of the required information is received — and thus drives up administrative costs.

The amount of paperwork collected by local departments of social services in New York State from Medicaid applicants seeking nursing home care was described during interviews with county officials as "a wheelbarrow full," "a 12-inch thick accordion binder," and "17 shoe boxes of documents." With so much

documentation required, it is reasonable to hypothesize that different counties, and even different workers within the same county, approach documentation collection differently. Indeed, the Institute's conversations with the counties, attorneys, and nursing home representatives supported this hypothesis.

Some counties or workers will generate only the required automated letters to applicants requesting needed documents as soon as they determine that the information is missing. Others may call the applicant first to request this information before following up with a formal letter. Others go directly to area banks to try to obtain documents about asset transfers, and then send a letter to the applicant. Most appear to use a combination of these methods. There is variation in which methods are used and how the counties or individual workers within those counties approach the application process. Some counties and individual social services staff describing themselves as more consumer friendly than others. Several counties mentioned that they approach eligibility determinations for skilled nursing facility care differently than they do for "regular" (non-long-term care) Medicaid, in that they are more helpful to consumers seeking nursing home eligibility. One county even moved the staff that processes nursing facility applications to an entirely different building from the staff that process regular Medicaid cases so that applicants would not feel as though they were receiving social services.

Only one county that was interviewed appeared to have a denial rate that matched the apparent high level of scrutiny that the county described as part of its eligibility process.

In addition to how counties may treat applicants for skilled nursing facility care, given how many documents there are to examine, it is likely that some workers or counties may scrutinize documents more than others. Indeed, Rockefeller Institute staff observed some minor differences among counties. Whether the differences in the level of scrutiny are large enough to create differences in rates of eligibility denials among counties is unclear. Only one county that was interviewed appeared to have a denial rate that matched the apparent high level of scrutiny that the county described as part of its eligibility process. Depending on the county, eligibility workers may only be responsible for making initial eligibility determinations for nursing home services. In other counties, similar workers may also be responsible for making eligibility redeterminations, preparing for fair hearings, or making regular (non-long-term care) Medicaid eligibility determinations. The workload and responsibilities of the eligibility worker may also play a role in the level of scrutiny for any one application.

Differences in Accepted Documentation

Another reason counties vary is because there are multiple types of documentation that counties can accept as valid for processing an application. As of July 1, 2006, all applicants for Medicaid are required to supply "satisfactory documentary evidence" of their US citizenship and identity per the amendments of the DRA. In New York State, applicants can provide one of the following primary documents to prove identity, citizenship, and

date of birth: US passport book/card, Certificate of Naturalization, or Certificate of US Citizenship.[17] As primary documents establish both citizenship and identity, applicants who submit a primary document are not required to submit secondary documentation. A variety of secondary documents establish either citizenship or identity. Thus, when primary documents are not available, two secondary documents can be used to establish citizenship (e.g., birth certificate) and identity (e.g., driver's license).[18]

Rockefeller Institute staff learned that not all counties will accept the same documents when processing applications. For example, at least one county accepted a Medicare card in lieu of requiring the applicant to produce a birth certificate, but another county only accepts a social security card or birth certificate. Although it is clearly outlined in statute that some documents may substitute for other documents (e.g., a passport in lieu of a birth certificate), it appears that not all counties follow these guidelines in similar ways.

In addition to what documents may be accepted, the depth of investigation into any one required document may differ. For instance, one interviewee revealed that at least one county requires an applicant to explain all deposits in excess of social security and pensions, and will require copies of the checks that assembled the deposit. Another county requires copies of all checks, regardless of the amount.

In New York State, individuals seeking nursing home admission (but not necessarily Medicaid eligibility) are required to submit a patient review instrument (PRI) to the nursing home, which may be completed by a qualified health care provider, and contains details about the applicant's current medical condition. While completion of the PRI is necessary for nursing home admission, it is not required as part of the Medicaid eligibility determination process. However, interviews for this research indicated that at least one county requires that applicants complete a PRI before the county will process the Medicaid application for nursing home care. Institute staff were told that this county requires an applicant's PRI to be approved by a separate medical unit in the county as part of the Medicaid eligibility determination process. This separate unit has nursing staff that will travel to nursing homes to make their approval. This additional process could delay the time it takes for an individual to become eligible for Medicaid.

Perhaps one of the most significant factors contributing to the county variance outlined in the Rockefeller Institute's 2009 report is the fact that counties sometimes use different codes to indicate that an applicant has been denied nursing home care because they transferred assets.

Complexity of Coding in the Medicaid Welfare Management System

Perhaps one of the most significant factors contributing to the county variance outlined in the Rockefeller Institute's 2009 report is the fact that counties sometimes use different codes to indicate that an applicant has been denied nursing home care because they transferred assets.

Within the state's database for tracking information on Medicaid applicants, known as the Welfare Management System

(WMS), the process for opening and coding an application and determining medical assistance status is complicated. The complete process is explained in detail in Appendix B; but, to summarize, the issues with coding differences are that counties are able to apply different codes for essentially the same function. For instance, there are four "coverage" codes that allow applicants to be eligible for all types of community-based medical coverage except nursing home coverage, any combination of which might be used as a proxy to estimate county denial rates.

There are also different "reason" codes that may indicate an applicant has been denied Medicaid eligibility because of excess resources. Reason codes are used to explain why a caseworker has made an eligibility decision and to generate notices for the applicant. Reason codes also will determine the content of the notice that is generated for the applicant in the WMS' Client Notices System (CNS). (Written notices are required by law.[19]) There are hundreds of reason codes,[20] and which code a county uses, even when there is a similar reason for denial, may vary, making it difficult to use reason code data for comparative analyses. Select codes are shown in Table 1.

Institute research revealed that counties may also use different reason codes to indicate an asset transfer. Counties sometimes use a certain code because the automated eligibility system generates a different type of report or notice for the clients. For example, at least two counties indicated they have used a "generic" code known as "Y99 Other — Manual Notice Required," to indicate a denial for reason of asset transfer. One county uses this code to tailor the case for each applicant. Another county uses the "Y77 Other — Undercare Case Maintenance" code when the caseworker believes that no other reason code fits.

The majority of counties in the study do not use generic codes. The large number of reason codes and the counties' use of them make it difficult to precisely compare denials for eligibility because of asset transfer.[21] To demonstrate the difficulty in comparing counties, Appendix B discusses this issue in more detail and shows the various codes that the counties in this study use to indicate an asset transfer. The definitions of the codes are similar, which could result in the use of different codes even when the reason for denial is the same.

County Capacity

Another notable difference among counties that could cause variation in rates of denial for asset transfer is administrative capacity. In particular, county administrative capacity varies by number of cases per staff member, the years of experience of the staff reviewing applications for nursing home care, and staff stability. Capacity differences may result in more available time for staff to work with applicants or banks to obtain the appropriate asset transfer documentation, or it may mean they have more time available to investigate potential asset transfers.

Even if counties have similar staff to caseload ratios, it does not necessarily mean that staff have similar workloads. A county worker might have a similar caseload but might also be responsible for preparing much of the documentation for fair hearings, as well as being responsible for recertifying eligibility (also referred to as "undercare"). For instance, in one county interviewed for this study, an eligibility worker who processes new applications (also referred to as "intake") has an approximate monthly caseload of 22 applications (or 264 per year), whereas another eligibility worker in that county handles undercare and has an average yearly caseload of 581. This contrasts with another county that was interviewed where a worker performed a similar number of intake cases a month, at 15 (180 per year); however, this worker was also responsible for undercare cases (230), and preparing much of the documentation for fair hearings.

Because eligibility workers often have several roles, it is difficult to compare staff to caseload ratios among counties or even among workers within the same county. When Institute staff were able to obtain comparable information about caseloads, differences still existed. Table 1 highlights these differences. County A had as many as 26 monthly intake cases and 600 undercare cases per each full time equivalent worker (FTE), while county D had only 16 monthly intake cases and 508 undercare cases per FTE. Two other counties had a number of intake cases somewhere in between, and county C had the largest number of undercare cases. Presumably, differences in counties' caseload amounts could affect the ability of the counties to thoroughly investigate asset transfers.

The stability of staffing in counties also varies. One county had three nursing home care eligibility workers, all of whom had been in their positions for nearly 30 years. Another had experienced consistent staff turnover, with eligibility workers staying less than a year, for the past few years. It was noted by counties, as well as by attorneys and nursing homes that deal with multiple counties, that staff turnover can diminish the ability of counties to scrutinize asset transfers.

Staffing turnover may impact rates of denial for asset transfers even more than staff to caseload ratios because learning how to process nursing home applications "can take years," according to several county officials interviewed. If nursing home eligibility staff are on the job for only a year or two before they move on, they presumably don't have as much experience to learn the "tricks of the trade" that would enable them to investigate asset transfers more thoroughly, often because they would not know what questions they could ask of applicants that would be more likely to yield information about possible assets.

Table 1. Select Counties' DSS Average Skilled Nursing Facilities (SNF) Medicaid Caseload Size Per Full Time Worker (FTE)

County	*Intake Per Month/FTE*	*Undercare/FTE*
A	26	600
B	15	230
C	20	760
D	16	508
E	22	581

Source: Rockefeller Institute county interviews

Other types of individuals may also be involved in helping to process an application. For instance, some counties have deputized outreach workers in nursing homes and hospitals. In other counties, entities hired by a hospital and not affiliated with the county may help applicants collect necessary paperwork. These people were called "financial counselors" in one county; in another, "eligibility patient advocacy specialists." Still other counties use only LDSS staff for the application process.

The Amount of an Asset Transfer Requiring Investigation

There are several areas where state and federal policies are not clear or where interpretations are left to the counties. These areas are also sources of possible variation. The first of these revealed during interviews with counties is that there are different levels at which an asset transfer may trigger a further investigation by a county worker. During the interviews with counties, Rockefeller Institute staff discovered that the transfer amount that may trigger an investigation varied from as little as $500 to as much as $8,000. However, even though there are differences in the amounts at which counties are likely to investigate a transfer, the counties interviewed were consistent in that most pay more attention to transfers occurring closer to the point of application, or transfers that occur in patterns.

Even though there are differences in the amounts at which counties are likely to investigate a transfer, the counties interviewed were consistent in that most pay more attention to transfers occurring closer to the point of application, or transfers that occur in patterns.

In 2010, New York State issued an administrative directive (ADM) suggesting that counties investigate all asset transfers over $2,000.[22] When asked whether counties found this guideline helpful, almost all said "yes." However, almost all also indicated they would continue to use a different amount (typically the amount they were previously using) as their guideline for determining when an asset transfer warranted further investigation.[23]

Fair Market Value

Another area where counties have discretion in interpreting eligibility rules is in determining the "fair market value" of some assets. One of the most common assets subject to a fair market value determination is real estate transfers. Fair market value is the estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Fair market value of real property or other assets may be established by an appraisal from a real estate broker or other qualified dealer or appraiser.[24] However, what is deemed fair market value differs among counties and even among appraisers, and assessments do not always reflect the true value of a property. For example, some towns will assess a property at 100 percent, whereas others will assess a property at a lower percentage rate, like 80 percent. Some counties ask for up-to-date real estate appraisals, while others use the value of the property based on older assessments. What value is used is often determined by the LDSS worker. To make the process less subjective, at least one county uses its own real estate

appraiser, who informs the LDSS if he agrees with the assessment that was provided.

Counties will sometimes negotiate fair market value with attorneys who are representing an applicant based on the rate of depreciation and deterioration of the property, particularly if a home is not occupied. One county noted that their LDSS attorneys like having the flexibility to negotiate real estate appraisals. For instance, if a house was appraised at $142,000 but had no one living in it, it would deteriorate and be worth only $118,000 in two years. By having the ability to negotiate the potential value of the property, both the county and the applicant's needs can be considered. The process can be highly subjective, however, and presumably varies by county.

Allowable Services and Their Value Under Personal Service Contracts

One way Medicaid applicants can legally shelter assets — so they are not counted as an asset transfer — is to transfer assets through what are known as personal care contracts. The value and types of assets paid through this exchange for services are vague, leaving discretion about what services for payment are acceptable via asset transfer, up to the counties. Personal care services can include, for example, housekeeping, laundry, shopping, meal preparation, personal hygiene assistance, bookkeeping, social interactions, and other essential functions.

It is up to the county to determine if a function listed in a personal care contract is "essential" and if the compensation for this service is at fair market value. One personal care contract might pay for a caregiver to provide companionship services such as conversation or reading activities, while another might pay for taking the applicant to a medical appointment. The value of these services can differ among personal care contracts. New York State refers counties to the US Department of Labor's Bureau of Labor Statistics' Occupational Outlook Handbook for general assistance in evaluating job duties and pay rates.[25] However, the counties often must use their own judgment in determining fair market value, which can differ based on the economy and the location where the services are being rendered. They must also determine what is reasonably exempt from asset transfer penalties in personal care contracts. Interviews indicated that the value of services under personal care contracts can vary among counties, suggesting that it may be easier to shelter assets via personal care contracts in some counties compared to others.

Circumstances Surrounding a Transfer

Counties also determine when there might be exceptions for an asset transfer, and their determinations can differ by county or even by workers within the same county. A New York State Department of Health administrative directive indicates that "all of the circumstances of the transfer will be considered as well as factors such as your age, health and financial situation at the time the

transfer was made."[26] This means counties could consider more or fewer circumstances of an individual, with much of the determination presumably being subjective. In fact, one county indicated its workers sometimes make home visits to better assess the situation of the applicant or their caregiver(s).

Source of Application

Counties receive Medicaid nursing home applications from a variety of sources, including from the applicant, the applicant's relative(s), a representative of the applicant, Medicaid estate planning attorneys, hospitals, or nursing homes. When Rockefeller Institute staff asked interviewees where applications came from in their counties, there was large variation. As shown in Table 2, some counties indicated they receive a high percentage of applications from estate planning attorneys, while other counties indicated that very few applications come from attorneys. Ten counties interviewed for this research revealed that the majority of applications come from families of persons needing nursing home care. Officials in only one county said they received most of their applications from nursing homes.

The source of Medicaid nursing home applications also may affect the level of scrutiny asset transfers receive. Officials in at least one county said they are likely to more thoroughly investigate asset transfers in applications that come from Medicaid estate planning attorneys, because they assume by hiring an attorney the applicant is trying to hide assets, while other counties indicated that applications with asset transfers from well-established Medicaid estate planning attorneys who specialize in Medicaid eligibility are scrutinized less, in part because they include more thorough documentation.

Table 2. Sample of County Rankings of Source of Medicaid Applications for Nursing Home Care

County	*Families*	*Attorneys*	*Nursing Homes*	*Applicants or Recipients*	*Other (e.g., hospital)*
1	1st (tie)	1st (tie)	2nd (tie)	—	2nd (tie)
2	1st	2nd	3rd (tie)	3rd (tie)	3rd (tie)
3	1st	3rd	4th	—	2nd
4	1st	3rd	2nd	4th	—
5	1st	2nd	—	—	—
6	2nd	1st	3rd	—	—
7	2nd (tie)	1st	2nd (tie)	2nd (tie)	2nd (tie)
8	1st	2nd	3rd	—	—
9	1st	2nd	3rd (tie)	3rd (tie)	—
10	2nd	3rd	1st	—	4th
11	1st	2nd	3rd	—	—
12	3rd	1st	4th	5th	2nd
13	1st	2nd	3rd (tie)	3rd (tie)	—
14	—	1st	2nd	—	—
15	1st	3rd	2nd	—	—

Note: Some counties reported that applications were distributed fairly evenly across sources, which is why rankings within these counties are tied for 1st, 2nd, 3rd, etc.
Source: Rockefeller Institute interviews with county officials

IV. Potential Opportunities for Cost Efficiencies

In addition to learning why there might be variation among counties, this research also sought to determine if reducing variation might create more efficiency, and whether there were opportunities for reducing costs if changes were made to Medicaid nursing home eligibility policies and processes. Rockefeller Institute staff determined that there are some ways to potentially reduce costs through administrative changes. These changes could be implemented regardless of whether or not eligibility determinations are made by the state or by counties. Other potential methods for reducing costs may require changes in Medicaid policy, either at the federal or state level. This section outlines findings from the research regarding opportunities to reduce costs. A later section describes which of these changes may have a more significant impact on cost reductions.

Potential Administrative Changes at the State Level

Change Some Eligibility Processes

In order to simplify the Medicaid application process, the requirement that Medicaid applicants meet face-to-face with Medicaid eligibility workers was eliminated on April 1, 2010. With the exception of New York City (which operates a separate system, and processes Medicaid applications by mail), nearly all of the counties interviewed for this study were consistent in their views that the elimination of face-to-face interviews for persons seeking Medicaid eligibility for nursing home care might initially increase the amount of staff time required to process applications. This is because some counties believe it is much more efficient to speak with Medicaid nursing home applicants in person rather than over the phone because the process is so involved. In fact, several counties indicated that after April 1, they would continue to encourage applicants for nursing home care to meet in person with county staff.

In a phone conversation nearly two and half months after the elimination of the face-to-face interview, one county indicated that it still performs face-to-face interviews for almost all of its Medicaid nursing home care applications. Only two applications (one from an attorney in New York City and one from the applicant's relative in California) had not had a face-to-face interview in the county since the requirement was removed. Officials in this particular county believe the face-to-face interview is helpful in reducing the amount of staff time required to process an application, and that nearly everyone who is offered the option still wants to come in for an interview because they also believe it makes the process easier. Several counties indicated that the application process for nursing home care should be more personalized than other human services, because it often is an emotionally trying time for applicants and their families. Therefore, it could be

helpful to have some staff dedicated to assisting consumers with questions.

Contrary to this view, officials in one county who were interviewed after the April 1 changes took effect indicated that they thought removal of the face-to-face interview was already improving the efficiency of processing applications. In addition, despite the reluctance of counties to relinquish use of the face-to-face meetings with Medicaid nursing home applicants, New York City has been operating a mail-in application system for years and is able to process applications and assist applicants while still ensuring program integrity.

The fact that New York City has been able to process Medicaid eligibility documents by mail for many years suggests that certain parts of the Medicaid long-term care application process, such as recertifications, could be centralized as a state function. Recertifications would be the easiest to centralize, since enrollees and counties have already gone through the complicated process of collecting initial paperwork.

The fact that New York City has been able to process Medicaid eligibility documents by mail for many years suggests that certain parts of the Medicaid long-term care application process, such as re-certifications, could be centralized as a state function.

Centralizing initial eligibility determinations, however, would be more difficult. This is because the initial eligibility determination process is so involved, and at times benefits from the personal interaction that applicants or their representatives have with county workers. Counties were divided about whether centralizing eligibility determinations would reduce costs.

Rockefeller Institute research supports the idea that centralizing eligibility workers in a single organization could eliminate some cost — for example, the need to employ 58 different county Medicaid administrators — and almost certainly reduce some of the variation among counties. But it could increase administrative costs because it may take longer for applications to be processed if workers are not available at the local level to assist applicants. This study could not assess all these costs and it does not address certain other issues arising from such a conversion — notably, questions including employee compensation and loss of local control.

If the state were to begin centralizing some of the long-term care eligibility processes, it could do so in phases, carefully assessing each phase. As stated previously, the first phase could be to centralize redeterminations. The second phase could allow applicants the option of having their application processed centrally, while still keeping county workers available should extra assistance be required. The state might also consider piloting centralization in a few counties (so that all applications in those counties are processed centrally by staff in Albany). In centralizing eligibility determinations, the state also could follow New York City's example and still retain a limited number of consumer and provider relations representatives at county offices (who could either be county or state employees) around the state to help people needing assistance with the application process.

Regardless of whether the state decides to centralize certain eligibility determination processes, it is worth noting that officials in at least one county believed that transferring the entire eligibility process to the state would result in more Medicaid fraud because the state would have less capacity to detect and investigate asset transfers, and could not do so "close to the ground." If the state moves toward centralization it may want to carefully assess whether the administrative savings of centralization are more or less than the savings that might have accrued through closer scrutiny of applications at the local level.

Automate Eligibility Processes Whenever Possible

One of the strongest and most consistent recommendations from counties about how to reduce administrative costs is to automate more of the eligibility process. Issues with the privacy of data sharing have precluded counties outside of New York City from using certain databases to obtain income information on applicants. All counties indicate that supplemental security income (SSI) cases are easier because they already contain key resource information. The boroughs that make up New York City have more data integration than the rest of the counties, making their job of obtaining income-related data slightly easier. Ideally, in addition to income and tax data, counties would like information about applicants' stocks and bonds, as well as access to Internal Revenue Service (IRS) 1099 forms.

One of the strongest and most consistent recommendations from counties about how to reduce administrative costs is to automate more of the eligibility process.

One county suggested expanding the state's CentraPort, a gateway to the Internet and state intranet provided by the New York State Human Services (NYSHS) intranet to LDSS, to include tax information that can be accessed by county Medicaid workers. CentraPort currently provides information and applications from various state agencies including the Department of Health, Department of Labor, Office of Temporary Disability Assistance, and the Office of Children and Family Services.[27]

In instances when an existing state database can provide counties with applicants' asset information, the counties requested that the information be provided in a more timely fashion. In particular, one county suggested more comprehensive automated checks at eligibility, and the ability to obtain information from the IRS about applicants. Automating processes is easier said than done, but it could significantly cut down on the amount of administrative time it takes county workers to process applications.

Improve the Process for Obtaining Asset Information from Banks

When an applicant applies for Medicaid nursing home care, most counties send a standard form letter to banks requesting information on the applicant's assets — with mixed results. Some banks are more responsive than others: some may produce the needed documents in a matter of days, while others may take months to produce similar documents. Almost every county

interviewed indicated that one way to save Medicaid administrative costs would be to cut down on the amount of staff time required to obtain applicants' asset information from banks.

Indeed, cutting down on the amount of time that counties spend obtaining paperwork from banks could significantly reduce administrative costs since "nearly two-thirds of a county worker's time is spent collecting information from banks." One county estimated that 80 percent of delays in investigating asset transfers are because they are unable to obtain information from banks. Another county suggested that the state intercede and make it a requirement that banks provide this information to counties within a certain time frame. Specifically, the county suggested that the state would benefit from instituting incentives for financial institutions to more readily respond to agency requests for information or documentation.

Cutting down on the amount of time that counties spend obtaining paperwork from banks could significantly reduce administrative costs since "nearly two-thirds of a county worker's time is spent collecting information from banks."

Automate Data and Scan Documents to Make Processing Easier for Eligibility Workers

In addition to relying on existing databases to cull information about applicants, a standard database could be developed to help county workers keep track of asset transfers. Currently, many of the counties track asset transfer information on a manual form. A database could be designed in a way to help county workers (or state workers), to recognize patterns in asset transfers more easily, relying less upon their individual experience to identify such patterns. It also could perform calculations for the workers, therefore reducing the chance for mathematical errors. Finally, scanning eligibility related documents would ensure that they are readily available to state workers when needed, and would allow for more efficient processing of applications than if the applications had to be submitted on paper and input again in an automated format.

Streamline the WMS Coding System

As noted in this research, the coding system for Medicaid is extremely complex. To reduce variation and potentially streamline future administrative costs, the system for coding could be simplified. Doing so would enable easier analyses of the data, reduce the likelihood of variation in how codes are used, and make it easier for new employees to learn how to use the system. More frequent training on using the codes would also help decrease variation. With or without more training, the state could also provide counties with more guidance about which codes they should be using under a variety of circumstances. However, reducing the number of codes in the system and providing such guidance to counties would require a significant investment of staff time, and any savings from streamlining the program would take years to realize. In lieu of revamping the system, further guidance from the state regarding appropriate coding methods could improve system integrity and allow for more accurate analysis of the data in the short term.

Institute a More Efficient Quality Assurance Process

In most counties, every application for Medicaid nursing home care that is processed by an eligibility worker must be reviewed by a supervisor. Requiring review of 100 percent of applications may be one way to try to ensure program integrity, but it is administratively costly. To reduce the amount of staff time required for reviewing cases without reducing program integrity, at least three counties have obtained a waiver from the state to change quality assurance practices. In fact, one county reviews approximately 6 percent (rather than 100 percent) of applications. The system is modeled on one that is used for other social services programs. If such waivers have shown positive results then it would make sense to expand this process to all counties in order to reduce administrative costs. If reviews are centralized, a similar streamlined quality assurance process may also make sense for the state. A centralized quality assurance process could ensure decisions consistently adhere to program rules and guidance.

Requiring review of 100 percent of applications may be one way to try to ensure program integrity, but it is administratively costly.

Consistency in Policy Enforcement

When cases go to fair hearing, some counties noted that what the Department of Health indicates in policy may not be consistent with fair hearing determinations. Although decisions from administrative law judges at fair hearings have no status as broader legal precedent, counties found that arbitrary enforcement of state administrative policies via fair hearing determinations hindered their ability to consistently enforce eligibility policies. As one county worker said, "being aggressive with denials doesn't help [lower costs] because the administrative law judge often sides with the consumer." Consistent enforcement of state policies by administrative law judges who oversee fair hearings could encourage county workers to be more diligent with challenging questionable asset transfers, therefore potentially reducing costs.

Limit the Number of Fair Hearing Adjournments

Another way to make the overall application process more efficient is to limit the number of times a case awaiting a fair hearing is adjourned, or limit the number of times an adjournment can be requested. Cases typically are adjourned at the request of applicants' estate attorneys so that they can preserve the date of their client's application (and therefore preserve the amount of time that has passed that counts toward the asset transfer look-back period). Although at times such adjournments are necessary, too many can waste county administrative staff time and contribute to delays in processing applications, sometimes resulting in applications pending for two-three years. While adjournments are occasionally done purposefully by attorneys to preserve the date of application, there may be ways to limit the effect they have on counties' staff time used to prepare for fair hearings.

Allow Quicker Processing of Community Spouse Income Exemptions to Avoid Fair Hearings

Every time a community spouse requests an increase in his/her allowable income, the case must go to a fair hearing.[28] Although there is a maximum resources limit, there is an exception when additional resources are needed to generate income. The process of determining exemptions requires the LDSS to pay a worker to prepare a summary and attend the fair hearing, make sure there is a room available, and pay a fair hearing officer, which is in many cases just a formality, as the spouse's request is usually approved. The process might work better if the county could simply have a form that could be mailed to the state and the state could approve or deny the increase rather than going through a fair hearing. Alternatively, the state could provide the LDSS with a guideline so the LDSS could approve or deny the increase themselves.

In some of the larger counties interviewed, deputized workers are used frequently and were seen as crucial to enabling the county to process a large amount of applications. One county has as many as 50-75 deputized workers.

Use WMS System to do Budgets for the Spousal Worksheet

Allowing WMS to do budgets for individual workers would reduce the amount of time it takes for staff to complete a spousal worksheet. This worksheet is complicated, and takes a tremendous amount of staff time to complete. Apparently, such an automated system may have been used several years ago but the county recommending this change was unsure why the system was no longer in place. Similarly, one county recommended that if this database could also do mathematical calculations, it would cut down on administrative time and decrease possible errors in calculating equations relating to spousal income.

Encourage the Use of Deputized and Outreach Workers

Some of the counties interviewed for the research use what they call "deputized workers" to assist individuals with applying for Medicaid nursing home care. One way of describing these workers is "counselors at nonprofit agencies [that] can and often help clients to complete and submit application forms, offer subsequent follow-up to track the progress of applications, and provide troubleshooting intervention to avoid denials. As such, these agencies may be, in effect, 'deputized' by the LDSS to assume some procedural aspects of the application or recertification process."[29] "To enable this kind of partnership, personnel at eligibility offices train deputized organizational staff and volunteers to verify original documents, make copies, and note or place a stamp on the original copies that they witnessed completed. Copies of the documents may then be submitted to eligibility offices in satisfaction of documentation requirements."[30]

In some of the larger counties interviewed, deputized workers are used frequently and were seen as crucial to enabling the county to process a large amount of applications. One county has as many as 50-75 deputized workers. Without such programs,

counties would either be overwhelmed with applications, delaying processing times, or they would have to hire more in-house staff. Hiring more in-house staff could be costly, and many counties find value in investing the time to train outreach or deputized workers. Such a recommendation is probably only cost effective in larger counties with a substantial amount of applications. In addition to using outreach workers, one larger county found that it could increase the efficiency of processing applications by using a "conversion worker." This is a worker whose sole job is to take persons who were previously eligible only for Medicaid community based long-term care, but not nursing home care, and process their application for nursing home care.

Separate Community Based Long-Term Care Cases from Community Medicaid

Only two counties explicitly stated that they do not track their community based long-term care cases separately from their nursing home cases. One county stated that they track cases separately on some reports but not on others (some state reports are integrated). Another county did not state whether or not their cases are tracked separately, but said they could separate cases by the worker who processed the application. Of the two counties that stated that they do not track their cases separately, both said that the cases could be separated, but one of these counties noted that it would have to be done manually and that the process would be time consuming.

In order to track processing times for Medicaid applications, counties rely upon a state data system, which makes it difficult for some counties to separate cases by the "type" (i.e., regular Medicaid, versus community based long-term care Medicaid, versus nursing home care Medicaid). At least two counties indicated that it would be helpful if community based long-term care and nursing home Medicaid cases, including the tracking of application processing times, could be more easily separated from regular Medicaid cases. This would enable counties to be more accountable and set goals for improving the efficiency of processing nursing home applications, potentially reducing administrative costs. Interestingly, one county used a Six Sigma strategy to identify how to cut down on the processing time of applications. The reduction in processing time was an improvement that was praised by county staff and noted as a significant improvement by at least one outside party interviewed for this study.

Employ Medicaid Estate Attorneys and Former Eligibility Workers at the New York State Department of Health

Because the Medicaid application process for nursing home care is so complicated and questions arise at the county level that require input from the state, it might to be helpful if the Department of Health had staff or contractors with the same type of expertise as those in the private sector (i.e., Medicaid estate planning

attorneys). Presumably, these attorneys would also be more adept at knowing when a person may be sheltering assets, as well as how to locate appropriate documentation more quickly.

Allow Administrative Directives to be Key Word Searchable

When there is a rule change or regulatory clarification in the Medicaid program, county offices are informed through what are known as administrative directives (ADMs). The Department of Health may issue several such directives every month. County workers indicated that keeping up with directives can be challenging and that when questions arise about policies and procedures, it can be difficult to sort through the hundreds of pages of administrative documents. A searchable database of administrative directives could help orient new eligibility workers more quickly, and also ensure that all counties (or state workers) can more easily access and follow guidance provided by the state regarding asset transfers. A revision of the Department of Health's Medicaid Reference Guide, although initially labor intensive, might also help workers better understand eligibility processing requirements.

Potential Policy Changes

State Actions

Examine the Pros and Cons of Limiting the Amount a Spouse Can Refuse

As is currently stated in New York State regulation, "[if] … a community spouse fails or refuses to cooperate in providing necessary information about his/her resources … MA [medical assistance] is denied for the institutionalized spouse because MA eligibility cannot be determined. However, an institutionalized spouse will not be determined ineligible for MA in this situation if; the institutionalized spouse executes an assignment of his/her right to pursue support from the community spouse in favor of the social services district and the department, or is unable to execute such an assignment due to physical or mental impairment; and to deny assistance would be an undue hardship…"[31]

In the course of this research, at least two counties recommended that there be more flexibility in the spousal refusal policy by allowing the amount that a spouse could refuse to pay to be capped or limited in some way.

There is no policy that states that a community spouse can refuse to pay for his/her institutionalized spouse without the risk of being pursued for restitution. The law is that Medicaid coverage for nursing home care cannot be denied for the institutionalized spouse if the community spouse refuses to pay, provided that the institutionalized spouse meets certain criteria (i.e., hardship requirement and assignment of support from community spouse to

the LDSS).[32] Consequently, the onus of recouping funds from the community spouse is entrusted to the LDSS worker, who can refer the matter to the court.[33] Recent case law in New York has supported this recovery mechanism; in 2006 *Clement v. Meagher* permitted the Nassau County DSS to recover money from the refusing community spouse. However, this process is expensive and likely very time consuming for an already overwhelmed LDSS staff. Additionally, spousal impoverishment laws protect only some of the community spouse's income and resources; excesses are considered accessible for contribution toward the cost of nursing home care.[34]

Clarify What Services Are Worth in Personal Care Contracts

New York State defines personal care services as follows: "A personal service contract, also known as a caregiver agreement, is a formal written agreement between two or more parties in which one or more of those parties agree to provide personal and/or managerial services in exchange for compensation paid by the party receiving the services."[35] Allowable services deemed "essential" could include anything from returning phone calls for an elderly parent to dog walking. Determining what services are included in a contract and their worth is complicated. The question for policymakers is whether it is good policy to allow an applicant to have paid a son or daughter a wage to do such things as pick up mail or walk the dog and then have those assets exempt from transfer requirements. Some limits on what may be included in personal care contracts and what those services are worth seems a reasonable cost control and an area where counties could use more guidance from the state.

Make Burial Fund Trusts Irrevocable

One way that individuals have legally transferred assets is by gifting assets to relatives for burial funds. As outlined in Medicaid law, "at the time of the initial application, the applicant cannot have more than $1,500 (or $3,000 for a couple) set aside as a burial fund. If the burial fund contains more than $1,500/$3,000, the excess is considered a countable resource."[36] One county noticed a spike in the use of burial funds and determined that a loophole was being used so that individuals applying for Medicaid nursing home care could transfer assets to relatives via a burial trust. The relatives of the applicant would then subsequently use the funds for other purposes. To prevent the misuse of such a loophole, burial trusts could be irrevocable, therefore preventing them from being used as a mechanism to shelter assets.

Broaden the Definition of "Estate" so Counties Can Collect More Money

"Estate" is defined in the Medicaid Reference Guide as "all real and personal property and other assets passing under the

terms of a valid will or by intestacy (intestacy means the deceased had not made a valid will)." Life insurance is a "contract between an individual(s) (owner) and an insurance company. The individual(s) pays premiums to the company that provides the insurance and the company in return agrees to pay a specified sum to the designated beneficiary upon the death of the insured."[37] For SSI-related applicants, life insurance policies are excluded resources if their face values total $1,500 or less. The "face value" of a policy is the death benefit or maturity amount of the policy, not including dividends or other special provisions.[38] The Deficit Reduction Act of 2005, which included several provisions affecting Medicaid eligibility for skilled nursing facility services currently allows annuities to be collected by the estate after a nursing home resident, whose care was paid by Medicaid, has passed away.

One county suggested expanding such collections to life insurance policies over a certain dollar amount. This policy could help reduce Medicaid costs by allowing the recovery of more estate money, although it also must be done carefully so as not to take away what may be owed or needed by a surviving community spouse.

When asked what changes in the application process would help improve efficiency, one county responded, "a shorter look-back period," and several others noted that the changes in the DRA of 2005 had significantly increased their workload, as well as administrative costs.

Potential Federal Actions

Evaluate the Costs and Benefits of an Extended Look-Back Period

The DRA of 2005 expanded the look-back period for asset transfers from three to five years. The goal of increasing the look-back period was to make it more difficult for higher income individuals to become eligible for Medicaid nursing home care services. This study did not assess whether this change has decreased the percent of applicants who are receiving Medicaid for nursing home care, but interviews with county officials did reveal that documenting five years of asset transfers has significantly increased the time it takes for Medicaid staff to collect necessary paperwork and process applications. At the same time, it has decreased the amount of time Medicaid staff have for in-depth investigation of questionable transfers.

Interestingly, when asked what changes in the application process would help improve efficiency, one county responded, "a shorter look-back period," and several others noted that the changes in the DRA of 2005 had significantly increased their workload, as well as administrative costs. Reducing the asset transfer look-back period would be contrary to the purpose of the DRA, yet given the responses of counties, it seems it may be worth evaluating the costs and benefits of this change.

Make Legal Shelter of Assets More Difficult

Several counties indicated that the DRA, because its rules regarding asset transfers are so complicated, has also allowed those wealthy enough to hire Medicaid estate planning attorneys a clear

Several counties indicated that the DRA, because its rules regarding asset transfers are so complicated, has also allowed those wealthy enough to hire Medicaid estate planning attorneys a clear way to legally shelter their assets, while persons with fewer assets who can't afford an attorney to help them navigate the process are often overwhelmed by the confusing rules of the process and the amount of application paperwork.

way to legally shelter their assets, while persons with fewer assets who can't afford an attorney to help them navigate the process are often overwhelmed by the confusing rules of the process and the amount of application paperwork. One way individuals have sheltered assets is through promissory notes. Although promissory notes have been legal for many years, the Deficit Reduction Act (DRA) tried to limit their use by classifying them as assets.[39] However, some interviewees indicated that the stricter rules regarding promissory notes have not limited their use, particularly when people can afford an estate planning attorney to help them navigate the rules. One county estimated that four-fifths of their county's Medicaid nursing home applicants had established promissory notes with the help of estate planning attorneys.

Although county officials believe that DRA was intended to decrease Medicaid costs by making eligibility stricter, some believe it has had the opposite effect and, in fact, has increased Medicaid costs because of loopholes. As stated by one county worker, "the process shouldn't be so complex that people have to hire lawyers to help them apply." Eliminating all loopholes, however, could be difficult. Rather, a better policy approach might be to encourage people to plan for their long-term care needs, and promote a reasonable way for individuals to share in the cost of their long-term care.

V. Priority Areas to Reduce Variation and Costs

This paper reviewed the many potential causes of variation in denial rates among counties and potential administrative cost efficiencies. Although the analysis initially sought to compare counties that were similar in some ways (population of persons over 65, total population, and per capita income) but different with respect to their denials, it was determined that the administrative data did in fact reveal variation in behaviors by counties in the eligibility determination process. However, it could not be determined precisely how much of the variation in measured denials across counties was due to real differences in county actions, and how much was due to differences in coding or other factors. As a result, the following section prioritizes some of the administrative cost efficiencies mentioned in this paper and explores how the state might also reduce the benefit costs of the Medicaid program.

Administrative Costs

A consistent message from all counties interviewed was that the process for Medicaid nursing home eligibility determinations is incredibly complex, and anything that could be done to streamline the process would likely reduce administrative costs. This would involve automating and centralizing administrative functions wherever possible. The state has already addressed streamlining and centralizing eligibility determinations for non-long-term care Medicaid populations. It could continue efforts to streamline long-term care Medicaid by automating eligibility checks via links with other databases, and streamline nursing home eligibility redeterminations, since these applications have already gone through a rigorous initial eligibility determination.

As noted earlier in this paper, another important administrative action the state might take to reduce costs would be ensuring compliance with its own policies when cases come to fair hearing. If an eligibility worker's cases are overturned in fair hearings because an administrative law judge is not required to follow state regulation, the eligibility workers may believe that their compliance with state policies will not be supported should they go to fair hearing, and they may have less motivation to comply with state policy in the first place, as well as less motivation to challenge questionable asset transfers in the future. This could ultimately lead to more people inappropriately receiving Medicaid benefits.

There were also areas where counties indicated that the state could provide more guidance. Guidance could help reduce variation, and depending on the type of guidance that the state provides, there also might be reductions in cost. Areas where guidance was sought that were mentioned in this paper, include: what is considered acceptable documentation for asset transfer; how best to determine the fair market value of property; how to evaluate personal care contracts; and under what circumstances different Medicaid eligibility and reason codes should be used.

Although the state has been working to provide clarification in some of these areas, more guidance does not necessarily mean that the counties will follow it, as was evidenced by counties' continued use of differing dollar amounts to trigger investigation into an asset transfer. Therefore, it may be just as important for the state to enforce its directives so they are more consistently applied. Rigorous enforcement may be especially important in instances where state guidance is specifically targeted at reducing costs.

Programmatic Costs

In addition to administrative cost controls, and perhaps more important for overall Medicaid costs, is that fact that Medicaid benefits represent a much larger cost than administration. (Medicaid administrative costs are approximately $1.1 billion in total, while program costs are over $50 billion.) Variation among counties could be indicative of too many or too few individuals receiving benefits. The state may therefore benefit from a more robust quality assurance system that ensures accuracy in eligibility determinations. Currently, counties review their own eligibility determinations and then those determinations are randomly reviewed by the state.

The state might consider changing the incentives of the current system so that people are not as motivated to shelter their assets in order to qualify for Medicaid in the first place.

During interviews with counties, many took pride in the fact that they were accurate in making eligibility determinations. A brief Rockefeller Institute analysis of fair hearing data from the state's Office of Temporary and Disability Analysis appeared to support this claim by counties.[40] If counties are indeed successful at making correct eligibility determinations, then variation among counties may have more to do with factors other than approaches to the eligibility process, such as the use of different codes to indicate a denial.

But even if the state was able to reduce variation through quality assurance processes, and was diligent in investigating asset transfers for the purpose of reducing Medicaid costs, there are larger policy issues that may impact who are receiving Medicaid benefits. As the system works right now, individuals who may have the means to pay for their own nursing home care recognize that doing so could quickly impoverish them. To avoid impoverishment, individuals have three choices: they can find ways to legally shelter some of their assets and qualify for Medicaid; they can pay for their nursing home costs (and hope they don't become impoverished); or they can purchase some type of long-term care insurance, including public or private insurance.

The least costly of these options for the state is having individuals purchase private insurance. The state might consider changing the incentives of the current system so that people are not as motivated to shelter their assets in order to qualify for Medicaid in the first place. The state might do this by encouraging people to purchase long-term care insurance. It could do so by implementing methods that have been successful at encouraging people to

buy regular health insurance. The state might also foster the growth of public-private long-term care insurance, by building on the New York State Partnership for Long-Term Care program; or be prepared to take advantage of recently enacted federal legislation known as the Community Living Assistance Services and Supports (CLASS) Act, which will encourage people to set aside savings for their long-term care needs.

VI. Implications of Research Findings for State Assumption of Medicaid Administration and Medicaid Costs

As noted previously, recently enacted legislation requires the state health commissioner to develop a plan for state assumption of administrative responsibilities and costs for the Medicaid program from local social service districts. The intention behind the legislation is to "save hundreds of millions in taxpayer dollars by consolidating operations, reducing costs and establishing statewide uniformity." Total administrative costs for Medicaid are approximately $1.1 billion for 2010-2011. Under the existing division of responsibilities, the total county contribution toward the administrative component of Medicaid is expected to be $329.8 million. The remainder of the non federal share, $221.5 million, will be paid by the state.[41] State policymakers will need to determine whether new efficiencies can reduce the cost of the state's newly assumed responsibilities, whether other changes in the state-local fiscal relationship may offset some such costs, and how to pay for any costs that remain.

As the legislation indicates, local employees may be transitioned to state employees, although it is unclear whether they would still perform all of the same duties they are currently performing. It is possible that the responsibility for Medicaid nursing home eligibility determinations could be shifted from the local districts to centralized workers in one location in the state, although this also is unclear.

During interviews with counties, respondents expressed mixed views about state assumption of county nursing home eligibility determination responsibilities. At least two counties supported the idea of relinquishing oversight of all aspects of the long-term care eligibility determination process to the state, with little, if any, role for workers at the county level. Several other counties felt strongly that workers at the county level (whether state or county employees) should continue to have a role in the eligibility determination process for nursing home care because the process is so complex. Interviewees expressed that eliminating a local role could result in more, not less, administrative time for processing eligibility because applicants for nursing home care tend to have many more questions and require much more personal assistance than other Medicaid applicants.

To ensure program integrity, it is reasonable to assume that there should be consistent application of eligibility rules, documentation collection, and processes among Medicaid workers. State assumption of some aspects of the Medicaid long-term care eligibility process and converting county workers to state workers could decrease some of the inconsistencies that were discovered during this research. However, it is not clear whether centralization or state assumption of administration would eliminate variation altogether, since Medicaid rules are interpreted differently by counties and by different workers within the same county.

It is also worth noting that there is a good chance that any administrative efficiencies the state may achieve by converting county workers to state workers will be offset, at least in part, by higher compensation costs as county employees become state employees. (Typically, state workers are compensated more than county employees.) At the same time, allowing county employees to become state employees may also eliminate the need for certain administrative positions, such as numerous county Medicaid directors. There are many trade-offs the state will have to consider as it studies how to assume administrative responsibilities from counties, and it will have to carefully evaluate the costs and savings of a state takeover.

A few additional issues that the state might want to consider as it evaluates how to begin assumption of Medicaid administration include the fact that locally based staff may be more aware of unusual factors that should be taken into consideration regarding an individual's circumstances, such as those surrounding the use of a personal care contract. Other issues, such as circumstances surrounding the value of real estate, may also benefit from a local perspective.

Regardless of whether the state centralizes certain aspects of the Medicaid eligibility determination process or not, this research points to the need for additional training for Medicaid staff on issues that cause variation. In particular, training on the use of WMS codes, the amount of an asset transfer that may require an investigation, and interpretations surrounding personal care contracts and real estate values, could be helpful in reducing variance and improving program equity and predictability.

VII. Conclusion

Few other states have such diffuse structures for administering and financing their Medicaid programs as New York. This research confirmed that there are many factors that cause program variation. But perhaps the most telling comment heard from interviews for this study was that there is variation even in how workers within the same county approach the eligibility process. This finding suggests that regardless of whether the state can reduce variation, it may never be able to eliminate it altogether. In any case, there is a need for more standardization and policy clarification, as well as consistent enforcement of policies whether eligibility determinations are done locally or by the state.

Although there may be some cost savings from the state assuming responsibility for county costs, some of these savings would take years to realize, and may not yield as much in savings as the state might anticipate, especially when compared to the costs of Medicaid benefits. State assumption of administrative responsibilities for Medicaid nursing home eligibility determinations would not be easy, since counties have long played a pivotal and hands-on role in this process, as well as a crucial role in helping New Yorkers in need. Yet, this research demonstrates that there are initial and pragmatic steps the state could take now to begin the process of centralization, as well as other ways to reduce costs both through administrative changes and policy changes. Documenting the savings from administrative and policy changes also would be important, as it could be politically contentious. But given the state's current fiscal crisis, and its growing long-term debt obligations, there has never been a better time for re-thinking how the state administers its Medicaid program.

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Appendix A

Table A. Summary of Comparisons of Paired Counties

County	*% of Elderly Medicaid Enrollees Denied Nursing Facility Services Due to Asset Transfers (1998-2008)*	*Asset Transfer Trigger Amount to Start Investigation*	*Reason Code(s) Used by Counties to Indicate Asset Transfer*	*Coverage Code(s) That May be Used by Counties for Asset Transfer Cases*	*Other Observations About Approach to Eligibility Determinations*
A	24.2	$2,000*	094, S82, U32, U40, U59	MA20, MA23	
B	3.7	$1,000	094, S20, S22, U20, U32, U40, U59, U51^, U52^	MA10	
C	1.0	$2,000	U32, Y99^^	MA10	
D	2.1	$1,000**	S70, S71, S82, U32	MA23^^^	
E	1.1	$1,000	No response	No response	
F	1.3	$3,000	S71, S82	MA10, MA20	
G	34.9	$500	S82, U20, U21	No response	Indicated that they provide extra scrutiny
H	0.8	$1,000	S68, 094, Y99	No response	
I	8.2	$2,000*	091, U32, Y77	MA01*^, MA10	
J	1.4	$1,000	C24, C82, 094, Y99^^	MA20, MA11	
K	14.5	$8,000	S70, U32, U40, U59, Y99^	MA23, MA6	
L	0.5	$3,000	070, Y99	MA10, MA20, MA22, MA23	Indicated that use of different codes may be why denial rates differs
M	6.3	$2,000	S82, U40	MA10, MA20, MA23	
N	2.8	$1,000	No response	MA19, MA20, MA21, MA11, MA23	Identified themselves as "consumer friendly"
O	15.5	$1,000	S70, S82, U32	MA10, MA20^*^	
P	29.1	$2,000***	S82	No response	

* was $500
** changing to $2,000
*** was $1,500
^ used pre DRA
^^ Rarely used (less than 1%)
^^^ Used for all long-term care cases including denials for nursing home services
*^ Used when penalty will run out in 2-3 months
^*^ Opened under MA20 if applicant/recipient (A/R) previously had MA06 coverage

Source: Rockefeller Institute interviews with county officials

Appendix B: Detailed Explanation of WMS Coding

The process for opening and coding an application and determining medical assistance (MA) status is as follows: When an application has been assigned a status (i.e., open, pending, denied, recertified, etc.) it also is assigned a resource verification indicator (RVI) code. The RVI codes indicate if, and how far back, the applicant's resources were verified by the LDSS. For example, an RVI code of 4 indicates that the applicant's/recipient's (A/R's) resources were verified for the entire look-back period; however, the applicant made a prohibited transfer of assets during that period, so they may still be able to receive Medicaid services other than nursing home services.

There are four coverage codes, MA10, MA20, MA22, and MA23 that allow applicants to be eligible for all types of community-based medical coverage, except nursing home services. The MA20 and MA22 codes are used when the applicant's resources have not been verified. The MA10 and MA23 coverage codes both indicate that current and past resources of the applicant have been verified, that the applicant has made a prohibited transaction, and that the applicant is eligible for all medical assistance except for nursing facility services.

RVI codes are linked to coverage codes in order to help determine services for which the applicant is eligible. For example, RVI 3 is linked to the MA20 and MA22 coverage codes and RVI 4 is linked to the MA10 and MA23 coverage codes. It often is MA coverage code 10 that is assigned to entitle the recipient to all Medicaid services and supplies except nursing facility services. Although the Rockefeller Institute's previous 2009 study used MA10 as a proxy for Medicaid skilled nursing facility denials for reason of asset transfer, the current study revealed that only some counties use MA10 to grant individuals community-based coverage while they wait to become eligible for nursing facility services; others use MA23 or MA20. One county interviewed for the study used MA22. Because counties are using different coverage codes in similar instances, it is difficult to make "apples to apples" denial rate comparisons among counties without additional research.

In addition to using different coverage codes in instances where a denial has occurred because of asset transfer, counties may also use different reason codes. The reason codes are used to explain why a caseworker has made an eligibility decision and to generate notices for the applicant. Reason codes are not linked in the same way that the RVI and coverage codes are linked. For example, reason code S70 indicates that the applicant will be granted medical assistance as an institutionalized individual with limited coverage due to a prohibited transfer during the look-back period. The reason codes also will determine the content of the notice that is generated for the applicant in the WMS' Client Notices System (CNS). (Written notices are required by law.[43]) There are hundreds of reason codes, and which reason code a county

uses, even when there is a similar reason for denial, may vary, making it difficult to use reason code data for comparative analyses. For example, some of the reason codes for denial of asset transfer listed in the WMS Code Card Index include S68, S69, S70, S71, and S72.[44] These codes are shown in Table B1.

Table B1. Sample of Medicaid Welfare Management System (WMS) Reason Codes Related to Denials for Asset Transfers

Reason Code	*Definition*
S70	Accept Institutionalized Individual Limited Coverage Due to Prohibited Transfer, No Excess
S71	Accept Institutionalized Individual Limited Coverage Due to Prohibited Transfer Excess Income, Resources and 6 Month Spend-down Met
S82	Accept Community Coverage without LTC
U20	Discontinue Medical Assistance due to Verification of Factors Which Affect Eligibility, Did Not State Unable to Get Information
U21	Discontinue Medical Assistance Due to Verification of Factors Which Affect Eligibility, Unable to Get Information, but Not a Good Reason
U32	Excess Income
U40	Excess Resources
U59	Excess Income and Resources
Y77	Other – Undercare Case Maintenance
Y99	Other – Manual Notice Required

Source: Rockefeller Institute county interviews and WMS Code Card Index

Counties Interviewed

Albany, Broome, Clinton, Delaware, Dutchess, Greene, Monroe, Onondaga, Orange, Rensselaer, Rockland, Schenectady, Suffolk, Tioga, Westchester, Wyoming, and New York City.

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About the Rockefeller Institute and the New York State Health Policy Research Center

The Nelson A. Rockefeller Institute of Government is the public policy research arm of the State University of New York at the University at Albany. The Institute focuses on the role of state and local government in the American federal system. The New York State Health Policy Research Center (HPRC), a program of the Rockefeller Institute, provides relevant, nonpartisan research and analysis of state health policy issues for New York State and national policymakers.

Endnotes

1 New York State Partnership for Long Term Care Web site at http://www.nyspltc.org/policy.htm, accessed 7/12/10.

2 Georgetown University, Long-Term Care Financing Project, at http://ltc.georgetown.edu/pdfs/natspending2007.pdf, accessed 7/12/10.

3 Nationally, $49.6 billion is spent by Medicaid for nursing homes services, which is $14.6 percent of all spending. Source: Kaiser Family Foundation. New York: Medicaid Spending, available at: http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=34, accessed 7/13/10.

4 Press release by New York State Assembly Speaker Sheldon Silver, "Silver, Farrell Detail Proposal For State Pickup Of County Share Of Medicaid Administration Costs: Plan Would Save Hundreds of Millions in Taxpayer Dollars by Consolidating Operations, Reducing Costs and Establishing Statewide Uniformity," March 25, 2010, at http://assembly.state.ny.us/Press/20100325/, accessed 8/16/10.

5 The Deficit Reduction Act (DRA) of 2005 was aimed at slowing spending in public programs including Medicaid and Medicare. Full text available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s1932enr.txt.pdf, accessed 8/16/10.

6 Denial rates were determined by taking the average number of Medicaid elderly enrollees in a county from 1998-2007 and comparing them with the number of Medicaid elderly enrollees who were denied eligibility for nursing facility services using Medicaid coverage code MA 10.

7 The number of denials was determined by dividing the average number of MA10 cases in a county by the average Medicaid elderly enrollees in that county.

8 New York State Budget Bill (A.9708-C/S.6608-B) January 19, 2010. Available at: http://www.assembly.state.ny.us/leg/?default_fld=&bn=A09708%09%09&Actions=Y&Votes=Y&Text=Y, accessed 6/27/10.

9 http://open.nysenate.gov/legislation/api/1.0/html/bill/A9708C.

10 To be eligible for Medicaid in 2009 in New York, an elderly individual, who is a supplemental security income (SSI) recipient, cannot have income of more than $767 per month or $1,117 per month for a couple and an individual cannot have assets of more than $4,350 (or $6,400 for a couple). For elderly individuals who are not SSI recipients, New York has an expanded the "medically needy" coverage option. The income limit for the "medically needy" is the same as that for SSI recipients (for both individuals and couples); however, the asset limit is lower, set at $2,000 for an individual and $3,000 for a couple. Source: Kaiser Commission on Medicaid and the Uninsured. "Medicaid Financial Eligibility: Primary Pathways for Elderly and People with Disabilities." February 2001. Available at: http://www.kff.org/medicaid/upload/8048.pdf, accessed 7/9/10.

11 New York State Department of Health (NYSDOH). Administrative Directive 10 OHIP/ADM-4. Available at: http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/10adm-4.pdf, accessed 5/23/10.

12 18 N.Y. Comp. Codes R. & Regs. 360-2.4(a)(1).

13 According to NYS Social Services Law §366(5)(e)(1)(vi) the "'look-back period' means the sixty-month period immediately preceding the date that an institutionalized individual is both institutionalized and has applied for medical assistance." The sixty-month "look-back" applies to transfers made on or after February 8, 2006.

14 NYSDOH Access NY Supplement A (DOH-4495A) at http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/10adm-5att2suppa.pdf, accessed 07/13/10.

15 Ibid.

16 NYSDOH 10 OHIP/ADM-4, "Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants" at http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/10adm-4.pdf, accessed 5/23/10.

17 NYSDOH Medicaid Resource Guide – Other Eligibility Requirements: Identity (updated November 2009, pp 449-450). Available at: http://www.nyhealth.gov/health_care/medicaid/reference/mrg/other-eligibility-requirements.pdf, accessed 6/23/10.

18 NYSDOH 10 OHIP/ADM-4, "Elimination of the Personal Interview Requirement for Medicaid and Family Health Plus Applicants."

19 NYS Social Services Law §366A(3)(b).

20 NYS Office of Temporary and Disability Assistance, Welfare Management System (WMS) Code Card Index (LDSS-4398), revised 2010.

21 Because of the difficulty of deciphering reason codes during the Rockefeller Institute's previous research study, the Department of Health recommended that the Institute use Medicaid code MA10 as a proxy for estimating the number of denials for Medicaid eligibility because of asset transfer.

22 The NYS Office of Children and Family Services defines administrative directives as "external policy statements designed to advise local service districts and voluntary agencies of policy and procedure which must be followed and require specific action" at http://www.ocfs.state.ny.us/main/policies/external/, accessed 7/21/10.

23 NYSDOH 10 OHIP/ADM-5, "Revised DOH-4220: Access NY Health Care Application and Release of DOH-4495A: Access NY Supplement A," at: http://www.health.state.ny.us/health_care/medicaid/publications/docs/adm/10adm-5.pdf, accessed 5/23/10.

24 NYSDOH Medicaid Reference Guide "Glossary."

25 New York State Office of Health Insurance Programs GIS 07 MA/019, "Evaluating Personal Service Contracts for Medicaid Eligibility."

26 NYSDOH 06-ADM-05 Attachment VI, "Explanation of the Effects of Transfers of Asset(s) on Medical Assistance Eligibility." Available at: http://www.health.state.ny.us/health_care/medicaid/publications/pub2006adm.htm, accessed 7/20/10.

27 CentraPort provides LDSS with state agency Web sites, directories, New York State laws and regulations, training tools, and access to the state's Legacy System. CentraPort also provides LDSS with access to policy directives and transmittals. Additionally, CentraPort has an automated application module (AutoApp), which allows LDSS workers to create and submit applications to the WMS system. Source: NYS OTDA 08-ADM-06 Attachment G "CentraPort – Fact Sheet." Available at: http://www.otda.state.ny.us/main/directives/2008/, accessed 6/25/10.

28 Per the NYSDOH Medicaid Reference Guide, "when the total countable resources are greater than $149,640 for the first continuous period of institutionalization, the local social services district calculates the couple's spousal share in order to determine the maximum amount of resources that can be retained by the community spouse.… The community spouse is permitted to retain from the couple's countable resources an amount equal to the greatest of the following amounts: (1) the state minimum community spouse resource allowance amount; (2) the spousal share up to the federal maximum resource amount; or (3) the amount established by court order or fair hearing." Source: NYSDOH. Medicaid Reference Guide – Resources: Resources Persons in Medical Facilities, Assessment/Determination (pp 331-333). Available at: http://www.nyhealth.gov/health_care/medicaid/reference/mrg/resources.pdf, accessed 6/23/10.

29 National Council on Aging. National Center for Benefits Outreach and Enrollment: Deputizing Community-Based Organizations. Issue Brief #5, March 2010, at http://www.centerforbenefits.org/NCBOEIssueBrief(Deputization).pdf, accessed 7/9/10.

30 Ibid.

31 18 NYCRR §360-4(10)(c)(3).

32 NYS Social Services Law §366–C(5)(B).

33 NYSDOH Medicaid Update, "Information Notice to Couples with an Institutionalized Spouse." April 2009 (Vol. 25, No. 5), at http://www.nyhealth.gov/health_care/medicaid/program/update/2009/2009-04.htm#not, accessed 5/26/10.

34 NYS Social Services Law §366-C.

35 NYSDOH GIS 07 MA/019, "Evaluating Personal Service Contracts for Medicaid Eligibility," at http://www.health.state.ny.us/health_care/medicaid/publications/docs/gis/07ma019.pdf, accessed 8/2/10.

36 NYSDOH Medicaid Resource Guide Resources: Burial Funds 2/05 (pp 303.1).

37 NYSDOH Medicaid Reference Guide – Resources: Life Insurance (p 264), at http://www.nyhealth.gov/health_care/medicaid/reference/mrg/resources.pdf, accessed 6/24/10.

38 Ibid, pp. 264-266.

39 http://www.elderlawanswers.com/Elder_Info/Elder_Article.asp?id=2751, accessed 8/2/10. Also see http://www.okhca.org/about/pdflib/mac/5-17-07_DRA_Summary.pdf, accessed 8/2/10. "The DRA also counts as assets some previously exempt financial instruments (such as certain annuities, promissory notes and mortgages)"at http://www.kff.org/medicaid/upload/7465.pdf, page 4, accessed 8/2/10.

40 Data for the analysis were obtained from ODTA on 1/26/10. The reports showed the number of fair hearings by county regarding denials of MA due to transfer of resources, although the data were not limited to nursing home eligibility. A second set of data included information on fair hearings involving budgeting, where due to the transfer of resources the appellant is "eligible," but must pay their costs until expenses equal the transferred amount (many of these involve individuals in nursing homes but not all). The data showed whether the local district determinations were affirmed by the state; were correct but information presented at the hearing gave a different result; whether there was no issue to be decided; whether local district determinations were reversed; or whether the local district withdrew their intended action.

41 New York State Assembly press release, at http://www.assembly.state.ny.us/Press/20100325/, accessed 8/16/10.

42 Rockefeller Institute of Government, Assessing Asset Transfer for Medicaid Eligibility in New York State, March 2009, at http://www.rockinst.org/health_care/long-term_care.aspx, accessed 7/7/10.

43 NYS Social Services Law §366A(3)(b).

44 NYS Office of Temporary and Disability Assistance, Welfare Management System (WMS) Code Card Index (LDSS-4398), revised 2010.