U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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August 11, 2015

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Subject: Responses to Questions for the Record; Hearing Entitled *Medicaid at 50: Strengthening and Sustaining the Program*

Dear Chairman Pitts:

This letter responds to your July 28, 2015, request that we address questions for the record related to the Subcommittee's July 8th hearing on Medicaid. Our responses to the questions, which are in the enclosure, are based on our previous work and knowledge on the subjects raised by the questions.

If you have any questions about our responses to your questions or need additional information, please contact us at (202) 512-7114, iritanik@gao.gov, or yocomc@gao.gov.

Sincerely yours,

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Director, Health Care

Carolyn L. Yocom
Director, Health Care

Enclosure

The Honorable Representative Pitts

Medicaid was created to provide assistance to individuals whose income and resources are insufficient to meet the costs of necessary medical services. However, GAO has identified a number of loopholes in Medicaid financial eligibility policies that allow individuals to artificially impoverish themselves in order to qualify for Medicaid coverage of long-term care. HR 1771 is intended to address one of the loopholes GAO identified that involves the use of annuities. Can you describe the loophole GAO identified and how much money individuals are sheltering as a result of this loophole? Also, do you think that this bill would help address the problem GAO identified?

Our most recent review of Medicaid long-term care eligibility identified four main methods used by applicants to reduce their countable assets—income or resources—and qualify for Medicaid coverage.[1] In particular, married applicants may reduce their countable assets by purchasing an irrevocable and nonassignable annuity that pays potentially large amounts of income for the community spouse over a short period of time without affecting the institutionalized spouse's eligibility. A representative from one law office we spoke to in an undercover capacity suggested that the creation of an annuity can be done quickly and therefore, is a tool for last minute planning. Medicaid officials from several states said that the use of annuities for the community spouse had increased over the past few years. Officials from three states said that the increase may be a result of the passage of the Deficit Reduction Act of 2005, because it clarified how annuities for the community spouse could be set up. HR 1771 would amend Title XIX of the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses, for purposes of Medicaid eligibility. We have not made recommendations in this area, and thus cannot comment on the potential impact of HR 1771. However, the use of community spouse annuities is one approach that has been used by applicants to reduce their countable assets and qualify for Medicaid. While we did not determine by how much applicants are reducing their countable assets in this fashion, state Medicaid officials, county eligibility workers, and attorneys who provided information on the value of annuities for the community spouse reported average values ranging from $50,000 to $300,000.

The Honorable Representative Bilirakis

GAO's April 2015 report on Medicaid demonstration programs included several recommendations to CMS. Can you please provide us an update on the status of these

[1]See GAO, *Medicaid: Financial Characteristics of Approved Applicants and Methods Used to Reduce Assets to Qualify for Nursing Home Coverage*, GAO-14-473 (Washington, D.C.: May 22, 2014).

recommendations, including any actions taken by CMS and whether those actions fully address the concerns raised by your report?

In our April 2015 report, we had three recommendations regarding the Department of Health and Human Services' (HHS) demonstration approval process.[2] HHS partially agreed with one recommendation, and agreed with the two others. HHS reported to us on July 28 on certain actions the department is taking, or plans to take, in response to our recommendations. Based on information provided to date, we believe HHS has taken positive steps to respond to our recommendations, but that more actions are needed to fully respond. We will continue to examine HHS's actions and any associated documentation provided by the department. We will soon update our website with the status of HHS's responses to these recommendations, and will do so in the future as part of our annual recommendation follow-up process. Our three recommendations and HHS's responses are as follows:

- We recommended that HHS better ensure that section 1115 Medicaid demonstration approvals further Medicaid objectives by issuing criteria for assessing whether section 1115 expenditure authorities are likely to promote Medicaid objectives. HHS partially agreed with this recommendation, noting that all section 1115 Medicaid demonstrations are reviewed against "general criteria" to determine whether Medicaid objectives are met. However, HHS did not indicate plans to issue these general criteria in writing, and we maintain that more-specific guidance is needed to improve transparency.
- We also recommended that HHS ensure that the use of these criteria is documented in its approvals of demonstrations; HHS concurred with this recommendation. In July, HHS informed us of steps the department had taken since the release of our report to clarify and document in approvals the criteria used to determine whether Medicaid objectives are being met. According to HHS, the department has identified in recent approvals which of the general criteria each approved expenditure authority promotes. While this may add some transparency, we still regard HHS's general criteria as not sufficiently specific to inform stakeholders of the department's interpretation of its section 1115 authority. Moreover, these criteria are still not available as written guidance.
- Finally, we recommended that HHS take steps to ensure that its approval documentation consistently provide assurances that states will avoid duplicative spending between federal Medicaid funds for demonstrations and other federal funds available to states for the same

[2]See GAO, *Medicaid Demonstrations: Approval Criteria and Documentation Need to Show How Spending Furthers Medicaid Objectives*, GAO-15-239 (Washington, D.C.: April 13, 2015).

or similar purposes. HHS agreed with our recommendation and told us in July that the Centers for Medicare & Medicaid Services (CMS) will be requiring all future 1115 Medicaid demonstration approvals to include information to verify that there is no duplication of federal funding, and will work with states to document how there is no duplication of federal funding as it processes demonstration actions. We will monitor CMS's efforts in this area and will consider this recommendation to be closed if the agency implements these planned actions.