

GAO

Report to the Chairman, Subcommittee
on Regulation, Business Opportunities,
and Technology, Committee on Small
Business, House of Representatives

July 1994

HEALTH CARE REFORM

Potential Difficulties in Determining Eligibility for Low-Income People



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United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-251424

July 11, 1994

The Honorable Ron Wyden
Chairman, Subcommittee on Regulation,
Business Opportunities, and Technology
Committee on Small Business
House of Representatives

Dear Mr. Chairman:

To obtain basic health care services, more than 30 million people relied on the Medicaid program in fiscal year 1992. Federal and state governments spent nearly \$120 billion to provide services to these people. However, millions of people with incomes below the poverty level are not now covered by Medicaid. Many of those who are potentially eligible do not apply and many who apply are denied enrollment and remain uninsured. Because a reformed health care system may expand coverage to many of the uninsured, as with the Medicaid program, some form of means testing may be required to determine eligibility.

Because of your concern about the number of people who are denied Medicaid, you asked us to examine problems applicants face in attempting to enroll. Specifically, our objectives were to identify the (1) reasons why people who may be potentially eligible for Medicaid are not being enrolled, (2) incentives hospitals have to facilitate enrollment of their patients in Medicaid, and (3) implications for eligibility determinations if health care reform is enacted.

Results in Brief

Many people who are potentially eligible for Medicaid never complete the application process. About half of the denials in the three states we visited were for procedural reasons—that is, applicants did not or could not provide the basic documentation needed to verify their eligibility or did not appear for eligibility interviews.

For the most part, state offices responsible for determining eligibility do not have the resources to routinely provide extensive assistance to all applicants. Furthermore, states know little about why people do not fulfill application requirements. In addition, two of the three states we visited do not know how many of those who are initially denied eventually reapply for Medicaid.

Because hospitals desperately need a payment source to cover the care of uninsured patients, in many states they rely on outside help—including private enrollment vendor firms—to enroll eligible patients in the Medicaid program. Vendor firms ensure that patients meet all application requirements. For their efforts, firms receive a portion of the Medicaid revenues they generate.

Health care reform may cover many more people with low incomes than are now being covered through Medicaid. Thus, more people will have to demonstrate eligibility before receiving assistance. Lessons learned from the Medicaid experience may help in dealing with the increased administrative burdens of expanded coverage.

Background

Since 1965, Medicaid, a jointly funded federal and state program, has provided payment for medical care for people with low incomes.¹ People receiving cash assistance payments under the Aid to Families With Dependent Children² program are automatically covered by Medicaid as are most people receiving assistance under the Supplemental Security Income program.³ In addition, people with income and assets that are too high to qualify for cash assistance but that fall within limits established by the states may qualify as medically needy.

Medicaid is a means-tested entitlement program.⁴ Recipients' income and assets cannot exceed financial standards established by each state. Within federal guidelines, states have considerable leeway in establishing Medicaid eligibility criteria—that is, the standards used to determine which people with low incomes qualify for Medicaid. States can establish income and asset standards at, above, or below federal guidelines. Thus, applicants in similar situations may be eligible for Medicaid in one state but not in another.

¹Medicaid is administered by the states within broad federal guidelines. Although the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) provides federal oversight, each state must designate a single state agency to operate its own Medicaid program.

²The Aid to Families With Dependent Children program provides cash assistance to families with children who are deprived of parental support because of a parent's death, incapacity, continued absence, or unemployment. All family members' income and resources, as well as their needs, are considered in determining the payment amount.

³The Supplemental Security Income program provides cash assistance to people who are 65 or older, blind, or disabled; had incomes of less than \$454 per month in 1993; and had no more than \$2,000 in assets, excluding a home and certain other items.

⁴Among its responsibilities, each state Medicaid agency must determine eligibility of applicants and maintain the Medicaid program's integrity.

States have established their own application processes to ensure that Medicaid is granted only to those eligible. First, applicants must complete applications that are often lengthy and complex. Then, they must provide documentation to show that their incomes and assets fall within specified levels and that they meet such other eligibility conditions as citizenship and residency. Usually, applicants are interviewed by eligibility caseworkers—often within state agencies responsible for managing welfare programs—who review their application packages with them. Finally, caseworkers make eligibility determinations on the basis of completed applications.

Scope and Methodology

To respond to your concerns, we reviewed Medicaid eligibility in three states—Georgia, Illinois, and Massachusetts.⁵ In these states, we met with state welfare agency officials, reviewed state agency reports, and visited eight local welfare offices to document the Medicaid application process, denial rates, and the reasons why people who are potentially eligible are not being enrolled in Medicaid. Our three-state review focused on people who had applied only for Medicaid and were denied. We did not review cases of people who had applied for cash assistance and, if approved, were automatically qualified for Medicaid. In our work at local welfare offices, we reviewed a randomly selected sample of case files in which Medicaid was denied because applicants failed to comply with program requirements.⁶ We analyzed the reasons for these denials and discussed them with eligibility caseworkers.

To identify hospitals' efforts to enroll their patients in Medicaid, we interviewed officials at six hospitals in these three states. Further, using a structured interview guide, we conducted a telephone survey of state hospital associations in the 50 states and the District of Columbia and selected state Medicaid agencies to identify the extent to which hospitals use firms to enroll people in Medicaid. In addition, we interviewed officials at six firms providing enrollment services in Georgia and Illinois. Officials at some of these firms provided selected case examples.

To identify enrollment issues that may exist for people with low incomes as a result of health reforms, we reviewed applicable sections of four

⁵In December 1992, we reported on the District of Columbia's Medicaid program. See District of Columbia: Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care (GAO/HRD-93-28, Dec. 29, 1992).

⁶We reviewed 190 denied Medicaid applications—from 7 to 39 at each of the eight offices we visited—to uncover the reasons applicants did not comply with program requirements. Samples from each office, which we selected judgmentally, did not represent the universe of denied applications.

health care reform proposals introduced in the Congress.⁷ Also, we reviewed several studies that addressed eligibility and enrollment barriers in the Medicaid program.

We performed our review between November 1992 and May 1994 in accordance with generally accepted government auditing standards.

Many Potentially Eligible Applicants May Not Be Enrolled in Medicaid for Procedural Reasons

Nearly one-half of denied Medicaid applications in the three states we visited were turned down for procedural reasons. Because applying for Medicaid is difficult for some people and hospital emergency care is available without regard to their ability to pay, some applicants may have little incentive to fulfill Medicaid application requirements. Further, limited resources prevent states from providing all the assistance needed by some applicants.

Many Medicaid Applicants Do Not Fulfill Application Requirements

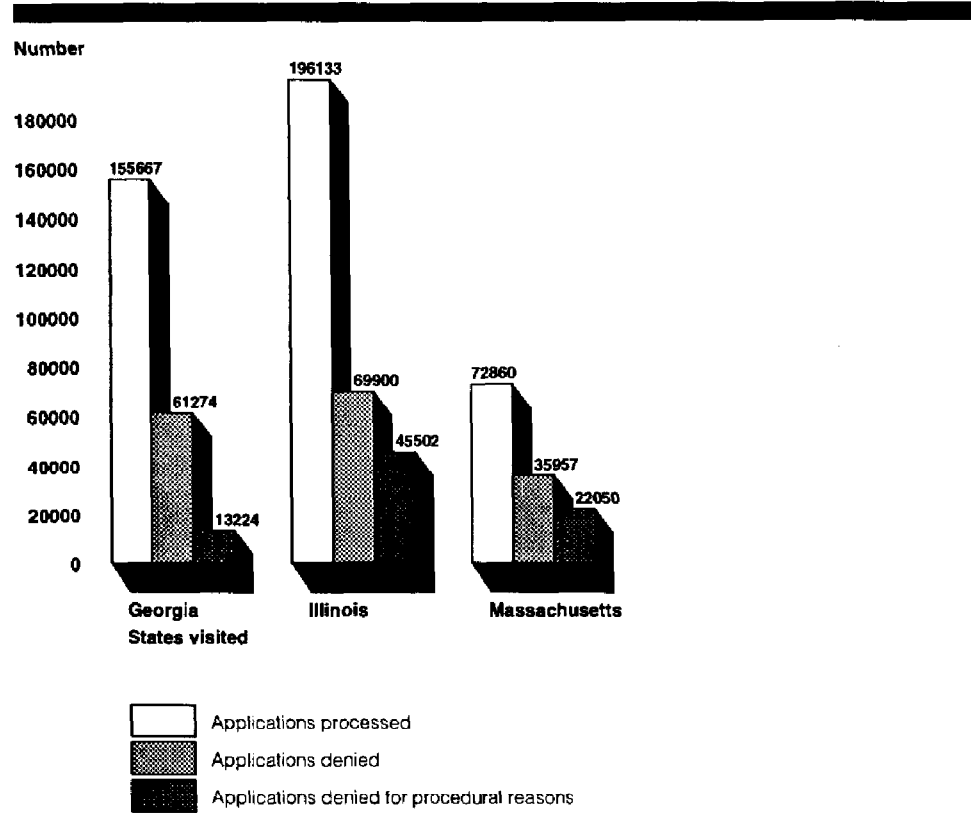
Each state's Medicaid agency is responsible for determining who is eligible for benefits. As shown in figure 1, more than 60 percent of the Medicaid applications denied in Illinois and Massachusetts and more than 20 percent in Georgia were denied for procedural reasons.⁸ Caseworkers denied these applications because the applicants did not fulfill all Medicaid application requirements.⁹

⁷The health care reform proposals we reviewed were (1) H.R. 3600 (the administration's proposal), (2) H.R. 1200 (McDermott), (3) H.R. 3222 (Cooper), and (4) S. 1770 (Chafee).

⁸Illinois and Massachusetts data are for fiscal year 1992; Georgia data are for fiscal year 1993.

⁹Medicaid applications are also denied when caseworkers determine that applicants do not meet eligibility criteria. For example, applicants may have income or assets that exceed eligibility standards.

Figure 1: Number of Medicaid Applications Processed, Denied, and Denied for Procedural Reasons in Georgia, Illinois, and Massachusetts



Notes: Applications processed include applications that were approved or denied.

Applications denied do not include applications that were withdrawn.

Illinois and Massachusetts data are for fiscal year 1992; Georgia data are for fiscal year 1993.

Illinois data are based on an 11-month time period as January data contained substantial errors.

Although the three states we visited prepare reports on the number of denied Medicaid applications and the reasons for their denial, the states report on applications denied for procedural reasons in different ways. For example, Massachusetts combines all procedural denials into one category; Georgia and Illinois report their procedural denials more descriptively. However, neither HCFA nor the three states regularly collect detailed information on specific factors that contribute to procedural denials. Furthermore, two of the three states do not maintain any data on

the number of denied applicants who eventually reapply for Medicaid. Appendix I provides more data on Medicaid denials in each state.

**Many Medicaid Applicants
Do Not Provide Supporting
Documentation**

Failure to provide documentation was the most significant reason for procedural denials at welfare agency offices in Illinois and was a major contributor to procedural denials in Georgia, according to statewide reports. In Massachusetts, our case file reviews showed that failure to provide the required eligibility documentation led to high numbers of procedural denials. Although required documentation varies, applicants must provide items to support several eligibility requirements. This documentation may include birth certificates to show citizenship, rent receipts or utility bills to show residency, wage data as proof of income, and documentation of the value of automobiles and insurance policies to report assets. Although applicants are not required to provide all of the items listed, table 1 shows the type of documentation that might be required to prove eligibility.

Table 1: Possible Medicaid Documentation Requirements in Georgia, Illinois, and Massachusetts

General	Completed and signed application; license or photo identification card; marriage license; proof of continued absence of parent (divorce decree, separation papers, death certificate, military service records, prison records); Social Security card or application for Social Security card for all household residents.
Citizenship	Birth certificate or other birth records (school records, baptismal certificates); citizenship papers or other proof of citizenship or alien status; resident alien form.
Residency	Copy of lease or deed; voter registration card; rent receipts or landlord's written confirmation of rent paid; utility bills; driver's license; school records indicating address of child and responsible relative's name.
Income	Pay stubs or employers' written confirmation of wages paid; if self-employed, copies of last tax returns; child support order; verification of child support and proof of payment; armed forces allotment; check or award letter for Social Security, Supplemental Security Income, veterans' benefits, workers' compensation or other disability; check or award letter for unemployment insurance or retirement benefits; proof of money from other sources (loans, gifts from friends or relatives, rental income, boarders, etc.); proof of scholarships for students out of high school.
Assets	Deeds; tax bills; mortgage contracts; contracts for deeds; title, registration, contract and/or payment book for all motor vehicles; fair market and book value of all owned automobiles and recreational vehicles; all individual and group life and health insurance policies; written statement from life insurance company or other proof that provides policy number and face and cash surrender values of each policy; statements from current bank or other financial institution; verification and proof of current value of all trust funds, stocks, bonds, safety deposit boxes, dividends, and annuities; proof of ownership and value of burial lots or prepaid burial plans.
Expenses	Copy of canceled check or receipt from child-care provider for child-care expenses; proof of tuition, loans, and expenses for students out of high school; paid or unpaid doctor, hospital, and dental bills or prescriptions; receipted bill or canceled check showing amount paid for health insurance coverage.

Applicants did not provide all required documentation in about 76 percent of Medicaid application procedural denials that we reviewed at local welfare agency offices. Although several other documentation items were involved in these denied applications, applicants did not provide income-related data in about 48 percent of the cases.

Welfare agency officials told us that many reasons account for the difficulty applicants have in completing the application process. The process is especially hard for people, such as nonnative English speakers or those who are poorly educated, who do not understand the requirements.

In a 1993 study,¹⁰ interviews with applicants who were denied Medicaid benefits showed that the most common reason given for failure to provide documentation was the limited amount of time applicants had for collecting and returning requested data.¹¹ In addition, applicants who did not provide documentation said that they did not know or understand what was required and were not able to obtain the items. In this study, case file reviews also indicated that although such items as Social Security numbers, birth certificates, and verification of unemployment were also not provided, income-related data were least likely to be provided.

Many Medicaid Applicants Do Not Attend Interviews

Failure to attend eligibility interviews was another reason for procedural denials at welfare agency offices we visited. During these eligibility interviews, caseworkers review the adequacy of completed applications and supporting documents provided by applicants—the basis for making eligibility determinations. When needed, caseworkers also suggest other documentation options to applicants to satisfy eligibility criteria.

Applicants did not attend eligibility interviews in about 24 percent of the Medicaid application case files denied for procedural reasons that we reviewed. In Illinois, failure to attend interviews was the primary reason given for procedural denials at three welfare offices, based on our case file review of 1 month's activities. At these offices, from about 66 percent to nearly 100 percent of the applicants denied for procedural reasons failed to appear. Illinois welfare agency officials believe that the most common reasons for missing these interviews are that applicants (1) have difficulty in arranging transportation and (2) are not given enough time to gather all required documentation to support their eligibility.

Lack of Resources and Incentives by States and Individuals May Contribute to Procedural Denials

Each applicant is personally responsible for applying for Medicaid and completing the application process, according to state Medicaid officials. HCFA does not mandate the type of assistance that states must provide to applicants during the enrollment process. However, welfare office staff said they do assist applicants in completing the application process whenever possible. For example, they said that they try to (1) review application requirements to ensure that applicants understand what items are needed, (2) identify where applicants can obtain documents,

¹⁰Improving Access to Medicaid for Pregnant Women and Children, Sarah Shuptrine & Associates, (Columbia, SC:1993).

¹¹In Georgia, applicants have 10 working days to provide documentation. However, if applicants cannot provide documentation within this time frame, they may request an extension.

(3) identify alternatives for required documentation, (4) grant extensions of time, and (5) request data from other agencies through the use of applicant authorization (consent to release) forms.

Welfare office caseworkers are required to help applicants when they request assistance; however, they cannot routinely provide the intensive services and assistance some applicants may need.¹² State officials said that staff reductions, combined with increasing applicant caseloads and budget constraints, prevent caseworkers from routinely providing all the assistance applicants need to qualify for Medicaid.

Further, a state's incentive to enroll all potentially eligible applicants in the Medicaid program may be countered by federal quality-control efforts. Currently, each state's federal Medicaid funding will be reduced if too many ineligible applicants receive benefits. However, a state faces no such penalties if eligible applicants are denied benefits.¹³ A quality-control system that focuses on identifying errors in enrolling ineligible applicants sends the message that denying benefits to eligible applicants is safe because there is no risk of sanctions, according to a state Medicaid program consultant. In addition, according to a Medicaid eligibility project director, the emphasis in welfare offices is on minimizing error rates—not on maximizing enrollments. According to this project director, if any doubts exist about an applicant's eligibility for Medicaid, the application is denied to avoid an erroneous approval.

People may lack the incentive to take necessary steps to prove eligibility. In many cases, a person's only incentive to apply for, and pursue, Medicaid eligibility is to obtain a source of payment for health care. This is especially true of those who apply only for Medicaid rather than other welfare benefits that provide cash assistance. However, uninsured people still have access to costly emergency health care because hospitals are required by law to provide care, regardless of a person's ability to pay. Given this access to health care, albeit minimal, these people may have

¹²A provision of the Omnibus Budget Reconciliation Act of 1990 contains a mandate for states to provide outreach to certain categories of Medicaid applicants beyond the welfare office. HCFA's guidance to states on implementing this provision of the law—referred to as eligibility worker outstationing—specifies that certain hospitals and other health facilities must have someone qualified to take Medicaid applications and assist individuals with the application process.

¹³States are required to report annually to HCFA on efforts to ensure that only eligible individuals are enrolled in the Medicaid program. HCFA reduces Medicaid reimbursement in states where the number of unqualified applicants exceeds a 3-percent eligibility-payment error rate, the national standard computed by averaging the rates for all states. However, errors that result in the wrongful denial of Medicaid benefits are not subject to this fiscal sanction.

little, if any, incentive to apply for Medicaid or to complete the application process.

The number of eligible people not enrolled in the Medicaid program is unknown. Further, no data exist to show the number of people denied Medicaid for procedural reasons who would have been eligible had they fulfilled all application requirements. However, the data do show that Medicaid enrollments increased when enrollment incentives shifted away from individuals. For example, the Medicaid enrollments increased because of the efforts made by hospitals.

Hospitals' Efforts to Increase Medicaid Enrollments

Because of a strong financial incentive, hospitals have taken aggressive steps on behalf of their patients to increase Medicaid enrollments. For example, some hospitals have contracted with private firms that provide intensive services to ensure that patients are enrolled in Medicaid. Also, hospitals have established their own units to assist patients in qualifying for Medicaid.

Hospitals' Incentive to Aggressively Pursue Medicaid Enrollments

Hospitals must provide emergency medical care to all people, regardless of their ability to pay. If a patient does not pay for the care provided, the hospital incurs costs for "uncompensated care."¹⁴ One source of potential payment for these unpaid hospital bills is the Medicaid program. For hospitals to bill the Medicaid program for services provided, a patient must be enrolled in Medicaid at the time of admission or apply for Medicaid within 90 days of the date of service.

Hospitals pursue all revenue sources, including Medicaid, to reduce their uncompensated care costs. Because hospitals have a strong financial incentive to maximize Medicaid enrollments, hospital officials said they cannot rely on each patient to assume the responsibility to apply for Medicaid and complete the application process after receiving services and leaving the hospital. Officials cite several reasons for patients' not applying for Medicaid. For example, patients may be too sick to comply with application requirements or too embarrassed to go to a welfare office to apply. Nevertheless, hospital officials believe patients should be responsible for obtaining Medicaid.

¹⁴Uncompensated care is the cost incurred by a hospital of services provided to patients for which the hospital does not receive payment. Uncompensated care may be provided deliberately (charity care) or unintentionally (bad debt). Uncompensated care is generated by patients who do not pay part or all of their hospital bill. Such patients may have no health insurance, or they may be underinsured.

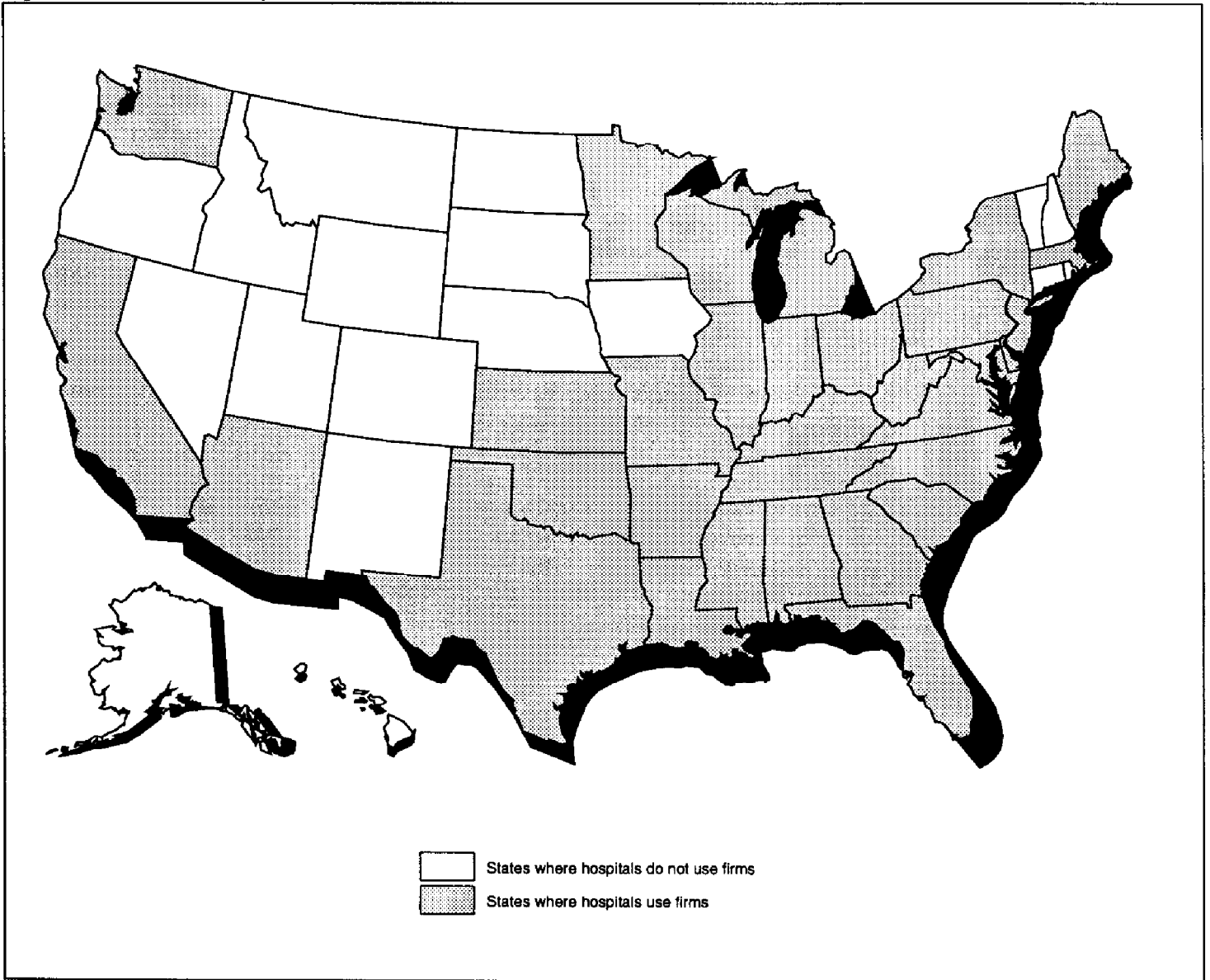
Generally, hospital officials believe the role of welfare offices is to enroll all eligible applicants in Medicaid. But hospital officials stated that it is unrealistic to expect welfare offices to provide all the assistance needed by some applicants. In addition, hospital officials have no confidence in the ability of discharged patients to complete the Medicaid process on their own. Quick identification and enrollment of eligible Medicaid patients is of paramount importance to hospitals—they want payment for their services. Accordingly, hospital officials stated that they must intervene on behalf of their patients.

In the absence of cooperation from patients who have already received services, and given the lack of assistance from welfare offices, hospital officials believe that they must use outside sources to ensure that eligible patients are enrolled in Medicaid. As a result, the hospitals we visited relied on enrollment vendor firms, hospital units, or both, to facilitate enrollments and to generate Medicaid revenues.

Hospitals in Many States Hire Private Firms to Enroll Eligible Patients in Medicaid

Many hospitals hire private enrollment vendor firms to help eligible patients qualify for Medicaid in many states. As shown in figure 2, hospitals in at least 32 states and the District of Columbia use private firms. State officials identified 34 different firms that were used by hospitals. One firm operates in as many as 15 states; some operate in only 1 state.

Figure 2: States Where Hospitals Use Enrollment Vendor Firms



Source: GAO telephone survey of state hospital associations in the 50 states and the District of Columbia and selected state Medicaid agencies.

Intensive Services Provided by Firms Have Successfully Enrolled People in Medicaid

Private enrollment vendor firms provide services to help ensure that eligible people are enrolled in Medicaid. These firms provide a wide range of assistance, including (1) identifying people who are potentially eligible for Medicaid, (2) assisting in overturning previously denied Medicaid applications, and (3) initiating and completing applications. For example, these firms exercise powers of attorney on behalf of their clients to obtain documentation needed to support eligibility, such as birth certificates; Social Security cards; rent receipts; and bank, wage, and salary statements. As a result, the firms can complete Medicaid application processes without applicants' active participation. However, HCFA's concern is that an applicant's appointment of an authorized representative must be made freely and without any coercion.¹⁵ Further, enrollment firms locate people in neighborhoods, make home visits to gather verification documents, arrange transportation and escort applicants to appointments, and deliver completed application packages to state agencies. They may also pay the costs of obtaining documents needed to apply for Medicaid.

Officials at the enrollment firms stated that the comprehensive assistance they provide usually is not provided by welfare agencies. These officials pointed out that eligibility caseworkers are often overworked and unable to provide the assistance many applicants need. Appendix II provides a detailed description of these firms and their operations.

These firms have been successful in enrolling people in Medicaid and have created significant revenues for hospitals. For example, Medicaid enrollments by one firm resulted in over \$3 million in inpatient Medicaid revenue at one hospital, during fiscal years 1990 and 1991—about 36 percent of the hospital's total inpatient Medicaid revenue during that time. The patients enrolled in Medicaid by two firms accounted for over \$9 million in inpatient Medicaid revenue at another hospital, during fiscal year 1990—about 14 percent of the hospital's total inpatient Medicaid revenue. However, despite intensive assistance provided to potentially eligible individuals, the firms are not always successful because some applicants cannot be located or refuse to cooperate.

Hospitals pay substantial fees for enrollment vendor services. During fiscal year 1992, for example, one hospital paid almost \$2 million to two firms for Medicaid enrollment efforts that resulted in Medicaid reimbursements of about \$10 million. Working on a contingency-fee basis, firms are paid only for cases in which patients are enrolled and Medicaid

¹⁵An applicant can authorize a firm to act on his or her behalf. States, if they so choose, have the right to insist that the applicant appear in person in cases where he or she can do so. States may not prevent the authorized representative from accompanying the applicant to the appearance.

reimbursements are obtained. Fee-structure arrangements in the vendor firm contracts we reviewed varied among hospitals. For example, at two hospitals, fees were based on a percentage of reimbursements generated, ranging from 14 percent to 20 percent. At another hospital, firms were paid on a graduated-fee schedule that decreased as the amount of reimbursement increased. Some contracts placed caps on the fees paid to these firms.

Some Hospitals Have Established Units to Help Enroll Eligible Patients in Medicaid

Five of the six hospitals we visited had established units within the hospital to assist applicants in enrolling in Medicaid. These units ranged in size from 1 to 18 staff members. Although some services provided by hospital units are similar to those of vendor firms, they are neither as intensive nor as extensive. For example, hospital staff primarily assist applicants in completing applications, tell them what documents are needed to establish eligibility, and suggest sources for obtaining the documentation, but they do not track down individuals to obtain the necessary documentation, as do the vendor firms.

Nevertheless, hospital assistance units also have been successful in enrolling people in Medicaid—especially while patients are in the hospital. The units at two Massachusetts hospitals enrolled over 90 percent of the patients for whom they submitted completed Medicaid applications to public welfare offices. However, some potentially eligible patients still fail to respond to hospital requests for documentation after they are discharged. In some of these cases, patients were discharged before the hospital discussed Medicaid eligibility. In other cases, even though the hospital discussed Medicaid eligibility with patients before discharge, patients did not provide required documentation.

For the most part, hospitals will continue to use outside sources to ensure that they receive Medicaid revenues. Hospital officials said that before hospitals would stop relying on outside sources for enrollments, welfare offices would have to serve as advocates for applicants and be more effective in ensuring that all eligible applicants are enrolled. However, these officials were very skeptical of the ability of welfare office staff to enroll all eligible applicants.

Federal and State Officials Accept Hospitals' Use of Outside Sources

HCFA and state Medicaid officials have accepted the role played by vendor firms and hospital units in enrolling people in Medicaid. The welfare offices in the three states we visited have constraints—including

increasing caseloads and decreasing resources—which prevent them from providing the more comprehensive assistance provided by vendor firms and hospital units, according to federal and state officials. In addition, it is not always appropriate for caseworkers to provide the type of assistance needed by some applicants for Medicaid. According to federal and state Medicaid officials, caseworkers cannot always be advocates for the needs of Medicaid applicants. For example, because caseworkers make eligibility determinations, they cannot work to appeal or overturn previous eligibility decisions. However, vendor firms can and do provide this service to hospital patients.

HCFA and state officials recognize that some patients who cannot pay their bills may not apply for Medicaid on their own after receiving services and leaving the hospital, and so they accept the need for outside sources. Further, these officials believe that hospitals' use of outside sources does increase access to Medicaid.

Health Care Reform

The Congress is considering numerous health care reform proposals, a number of which call for expanded—or even “universal”—health care coverage. As a result, many more people with low incomes may be eligible to receive assistance from the government—through either a federal subsidy or a voucher—which could be used to pay their health care expenses. However, before this assistance is given, each person must apply and be evaluated according to certain eligibility criteria.

Conclusions

The Medicaid program's experience with eligibility determinations provides insights for health care reform. Tension has always existed between access and accountability in the Medicaid program, and this condition may continue. As long as states have limited funds and must account for spending them only on qualified individuals, applicants will have to provide documentation to demonstrate their eligibility for program benefits. Because some applicants do not or cannot provide the documentation needed to determine eligibility, they will be denied Medicaid. As a result, access may be denied to eligible people with low incomes.

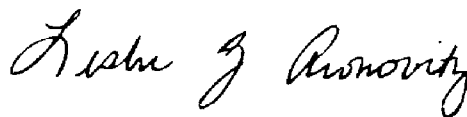
Hospitals, on the other hand, which have a strong incentive to get paid, take aggressive action—including hiring vendor firms—to ensure that eligible patients are enrolled in Medicaid. Although hospitals receive more

Medicaid revenues than they would without aggressive pursuit, they must pay part of their increased Medicaid revenues to these firms.

As reform efforts move to expand health care coverage, more people will have to apply for government assistance and document eligibility. However, people will most likely continue to face difficulties in meeting application requirements, even with health care reform. Therefore, to ensure that all eligible people receive assistance from the government, the administrative burdens of determining eligibility will increase greatly. As part of implementing any health care reform proposals, then, the Congress must determine the appropriate balance between increasing access to health care and maintaining program integrity.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to the Secretary of HHS and other interested parties and make copies available to others on request. Please call me on (202) 512-7119 if you or your staff have any questions. Other major contributors are listed in appendix III.

Sincerely yours,



Leslie G. Aronovitz
Associate Director
Health Financing Issues

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Abbreviations

HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

States' Data on Medicaid Denials

The three states we visited, Georgia, Illinois, and Massachusetts, prepare reports showing the number of applicants enrolled in the Medicaid program and the number denied enrollment. Although these states identify the reasons for Medicaid denials, two of the three states provide only general reasons for procedural denials. States themselves have not performed in-depth assessments to identify specific factors causing procedural denials.

States' Reports Provide General Data on Procedural Denials

State welfare offices in Georgia, Illinois, and Massachusetts prepare reports showing the disposition of Medicaid applications. Generally, these reports identify the number of applications processed—the number of applications approved and denied—and the reasons for denials. Although report formats vary by state, the reasons reported for denied applications are somewhat similar. For example, these states identify when an application is denied because an applicant fails to meet specific Medicaid eligibility criteria—that is, if an applicant's resources exceed allowable income and asset levels. However, although similar, the reasons reported by the states for procedural denials are also fairly general.¹⁶

A Medicaid applicant may be required to provide a number of items to verify that eligibility criteria have been met. Applicants' failure to provide the items needed to verify eligibility contributed significantly to Medicaid procedural denials in the three states we visited. However, reports of state welfare offices neither identify the specific items that applicants fail to provide nor summarize the items that are most difficult to provide.

Currently, case files must be reviewed to determine the verification items that applicants fail to provide and the extent to which they are not provided. State reports do not identify the specific items that applicants fail to provide. Generally, states have not performed in-depth assessments. Georgia, recognizing its own limitations, hired a consultant to evaluate reasons for procedural denials and found that applicants were least likely to document their wages, especially when the applicants were paid in cash. According to a Georgia Medicaid official, the state is assessing several of the consultant's recommendations for reducing procedural denials. In the next year or two, Massachusetts will begin a project to assess the need for some of the verification items requested to determine Medicaid eligibility.

¹⁶In this report, procedural denials include applicants who fail to provide information needed to verify eligibility and applicants who are uncooperative, such as those who fail to attend eligibility interviews.

Further, it is difficult to determine from the states' reports whether applicants restart the application process after being denied Medicaid. Neither Georgia nor Massachusetts identifies Medicaid reapplications by those who were previously denied. Illinois identifies the percentage of applications that are reapplications—state reports showed that reapplications accounted for about 26 percent of the applications processed in fiscal year 1992—but its reports neither identify applicants who were subsequently enrolled nor distinguish between previously denied applications and those that were withdrawn.

Information on Enrollment Vendor Firms

Hospitals contract with private enrollment vendor firms to assist patients in complying with Medicaid's eligibility requirements. For the most part, these firms provide more comprehensive and intensive services than do the caseworkers in local welfare offices, and they serve as advocates for the applicants, according to vendor firm officials. Without the intervention of vendor firms, hospital officials believe that they would lose a revenue source for covering medical costs of uninsured patients identified as potentially eligible for Medicaid.

Enrollment Vendor Firms Provide Intensive Services

Enrollment vendor firms tailor their services to meet the specific needs of people applying for the Medicaid program. These services help applicants solve the problems they encounter when applying for Medicaid. For example, the firms can (1) provide transportation to welfare offices or to sources of needed documentation, (2) pay the costs associated with obtaining the documentation needed to apply for Medicaid if applicants cannot afford to pay, and (3) offer interpreting services if applicants do not understand English.

Also, firms can use powers of attorney or consent-to-release information forms to authorize them to act on applicants' behalf. As a result, the firms gather the documents needed to verify eligibility and attend the eligibility determination interviews in place of applicants. In these cases, the applicants are relieved of many of the frustrations associated with applying for Medicaid. In addition, as applicants' authorized representatives, the firms are notified of the disposition of applications. Therefore, the firms can take further action to appeal Medicaid denials, if necessary.

The following example shows the type of services provided by enrollment vendor firms to ensure that patients are enrolled in Medicaid and that hospitals receive Medicaid revenues.

A man was hospitalized with burns over 30 to 40 percent of his body, as a result of an electrical shock. This patient's hospital bill totaled \$300,000. In this case, the hospital initiated and submitted an application for Medicaid after it determined that the patient was potentially eligible. However, the patient was unable to provide the documentation needed to meet eligibility requirements because he was incapacitated. As a result, the patient was denied Medicaid.

The hospital referred the case to an enrollment vendor firm. The firm contacted the applicant and helped him submit another Medicaid application, after the patient was

Appendix II
Information on Enrollment Vendor Firms

discharged from the hospital. However, the firm relied on the willingness of the applicant to comply with Medicaid's procedural requirements because he would not sign a power of attorney. Although the applicant attended the eligibility interview, he was denied again because he did not bring documentation to support his birth date, place of birth, Social Security number, and income.

On learning of the applicant's second Medicaid denial, the firm made several telephone calls to the applicant to get his cooperation. As a result, the applicant cooperated with the firm and signed a power of attorney which allowed the firm to act on his behalf. The firm appealed the denial and proceeded to gather the documentation that the applicant previously was requested to provide. The firm (1) took the applicant to the local Social Security office to obtain a statement verifying his birth date, place of birth, and Social Security number; (2) requested the applicant's employer to verify income; and (3) contacted the applicant's bank to obtain verification of bank account balances. The firm submitted all documentation to the local welfare office, which approved Medicaid coverage for the applicant.

Vendor firms are able to go into neighborhoods to locate people and to help them apply for Medicaid. For example, firms can work to find discharged patients who are homeless or who have given incorrect addresses and can locate the residences of unidentified hospital patients. Some firms employ off-duty police officers or security guards to locate discharged patients in dangerous neighborhoods, when necessary.

The following is an example of how an enrollment vendor firm obtains information on an unknown patient for a hospital and enrolls the patient in the Medicaid program.

An unresponsive, unidentified man was found on a public sidewalk. The man was admitted to a hospital, where emergency surgery was performed for a subdural hematoma. When there were no inquiries from the public, the hospital referred the case to an enrollment vendor firm to assist in identifying the patient.

The firm first determined where the patient was found and visited the address. Finding no one at the address, the firm left a notice in the mailbox. When the firm received no response from the notice, it obtained the telephone number for the address from an address-telephone directory. Through subsequent contact, the firm learned that the hospital patient was a transient who, in exchange for light labor, slept in a garage at the address. Then, the firm was able to obtain the patient's name, birth date, place of birth, and through the Social Security office, the patient's Social Security number. In addition, the firm discovered that the patient was receiving Supplemental Security Income checks at another address. The firm visited the other address and found the patient's sister, who

provided (1) the patient's personal identification, (2) proof of receipt of Supplemental Security Income, and (3) the necessary signatures. This case occurred in a state where people who are receiving Supplemental Security Income must file a separate Medicaid application. The firm represented the patient at the Medicaid interview, where no additional documentation was needed. The welfare office approved the Medicaid application.

Vendor firm officials stated that they are particularly adept at establishing cases for Supplemental Security Income as a basis for establishing Medicaid eligibility. The officials stated that they can research applicants' medical histories and can obtain the documentation needed to prove medical and psychological disorders.

Intensity of Assistance Provided by Enrollment Vendor Firms

The intensity of the assistance provided by enrollment vendor firms varies from case to case. However, cases can involve a considerable amount of the firms' time and effort. For example, an official at one firm said that the firm makes an average of 10 to 15 contacts with an applicant before a Medicaid application is submitted for an eligibility determination. This firm's efforts include weekly mailing and weekly telephone calls to the applicant. The following example shows that firms may have to be persistent in trying to enroll applicants in the Medicaid program.

The child of a single, uninsured working mother incurred a \$20,000 hospital bill. The mother also had young twins at home. The hospital referred this case to an enrollment vendor firm after determining that it was a potential Medicaid case. After contacting the mother, the firm initiated and submitted a Medicaid application. The firm gave the applicant a list of the verification items she would have to provide. However, the applicant did not provide the requested items and Medicaid coverage was denied.

Upon learning of the denial, the firm contacted the applicant twice weekly for a period of 2 months to get her to cooperate by either providing the verification documents or signing a power of attorney that would allow the firm to obtain the documents. However, during this time, the applicant had pressing demands on her life. In addition to working, she was caring for her sick child and young twins. When the applicant stopped responding to the firm's many telephone calls, the firm assigned another caseworker.

Eventually, the applicant responded and submitted the verification items and a signed power of attorney to the firm. The verification items included copies of a birth certificate, a Social Security card, and pay stubs. According to an official at the firm, the applicant had been carrying these items in her purse for some time but did not attach any priority to

providing them to the firm. The signed power of attorney allowed the firm to appeal the denial successfully and obtain Medicaid coverage for the children.

An official at another firm that specializes in disability cases said that in contacting applicants, securing documentation needed to verify eligibility, and dealing with Social Security and Medicaid offices, the firm makes an average of 150 contacts per case before an applicant is eligible for federal disability payments and the hospital receives its Medicaid reimbursement.

Enrollment Vendor Firm Staff

Enrollment vendor firms employ staff who usually have some college education, at a minimum. However, they prefer that their staffs hold bachelor's degrees. Some firms prefer bachelor's degrees in psychology or sociology, and a few firms want staff with degrees in social work. One firm, which specializes in disability cases, requires a number of its staff to hold master's degrees in social work or clinical psychology and has hired a number of former nurses.

Firms hire employees who have work experience, particularly in the health care industry. They prefer staff with knowledge of Medicaid and other public assistance programs. However, one firm will not hire former welfare office caseworkers because the firm believes that these workers cannot function as advocates for its clients. Firms also require staff members to possess certain interpersonal and communication skills, such as compassion and sensitivity, that are needed to understand and help people applying for Medicaid. Staff at these firms must educate people on their responsibilities and expectations in applying for Medicaid and the benefits of having health insurance. One firm hires people with sales experience because they have skills useful in encouraging and persuading people.

Firms Train and Update Staff on Medicaid Program Changes

Officials at enrollment vendor firms stated that their new employees receive on-the-job training for periods of 3 to 18 months before they work on their own with Medicaid applicants. Senior staff members teach new employees how to contact Medicaid applicants by mail and telephone. In addition, new hires are initially briefed on Medicaid and other public assistance programs and then given considerable classroom training on the programs' rules and regulations.

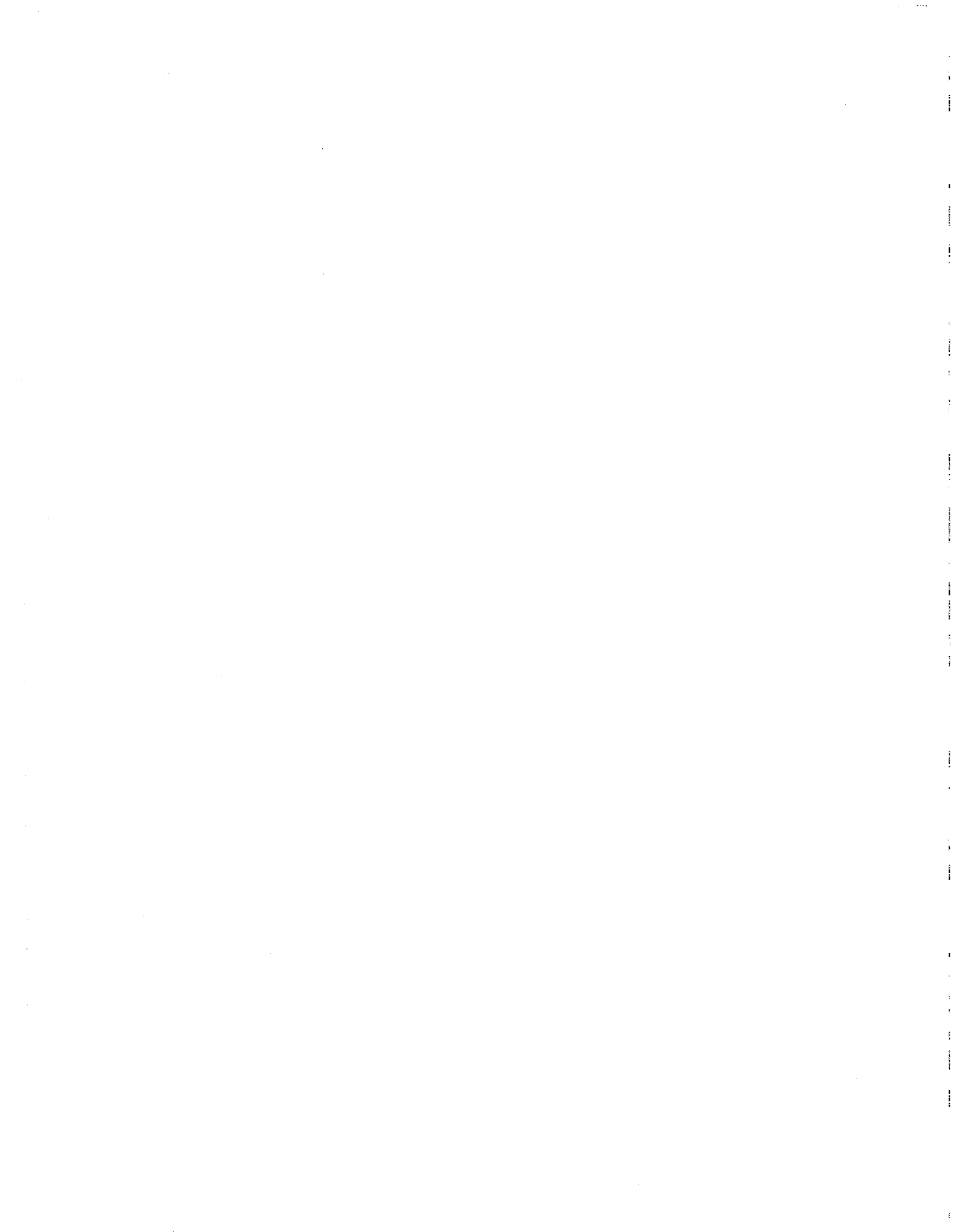
To inform their staffs of changes to Medicaid rules and regulations, firms issue internal memoranda and hold classroom training. An official at one

Appendix II
Information on Enrollment Vendor Firms

firm stated that staff cannot be hired and trained quickly enough to meet the strong and growing demand by hospitals for its services. Consequently, the firm has turned down hospital business.

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