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DISTRICT OF COLUMBIA

Barriers to Medicaid Enrollment Contribute to Hospital Uncompensated Care

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The Honorable Ronald V. Dellums
Chairman, Committee on the District
of Columbia
House of Representatives

The Honorable Thomas J. Bliley, Jr.
Ranking Minority Member
Committee on the District of Columbia
House of Representatives

Uncompensated care costs are becoming a significant problem for many hospitals in the District of Columbia due to the increasing number of uninsured patients and the escalating cost of health care. The cost of uncompensated care at hospitals in the District increased from $157 million in 1987 to $228 million in 1990. Against this increasing burden of uncompensated care, Medicaid reimbursement has grown in importance as a revenue source for hospitals that serve a high percentage of low-income and indigent patients. Even with Medicaid funds, however, many hospitals face budget pressures that threaten their ability to provide adequate health care to their communities.

This report responds to your request that we examine the problem of uncompensated hospital care in the District of Columbia and determine whether hospitals are receiving all Medicaid revenues for which they may be eligible. Our specific objectives were to (1) determine the extent to which uncompensated care is a problem for hospitals in the District, (2) examine the process for obtaining Medicaid enrollment and its relationship to Medicaid reimbursement and uncompensated care, and (3) review the process for obtaining Medicaid enrollment in the District and identify potential barriers to enrollment.

To do this work we conducted interviews with representatives of 12 of the 13 nonfederal, nonpsychiatric hospitals in the District of Columbia that participate in the Medicaid program. We analyzed financial and operating data provided by each hospital and by the District of Columbia Hospital Association (DCHA). (Appendix I lists the hospitals included in this study.) We also interviewed District government officials and analyzed data on caseloads and staffing trends in District welfare offices. In addition, we interviewed officials of the federal Health Care Financing Administration (HCFA), the Children's Defense Fund, and the American Public Welfare Association, and researchers concerned with Medicaid eligibility issues.

This study focuses primarily on the uncompensated care generated by hospital inpatients and on Medicaid enrollment for such inpatients. The scope of this study is limited to the District of Columbia. We did not examine programs in other states.

The results of our work are summarized below and discussed in detail in appendixes II, III, and IV. Our work was performed in accordance with generally accepted government auditing standards between September 1991 and August 1992.

Background

Hospitals in the District of Columbia receive payment for services from several sources, including private insurers, Medicare, Medicaid, the District of Columbia government, and patients' out-of-pocket payments. [1] These payers do not all pay the same amount for the same services, and some pay less than a hospital's cost of providing services. Hospitals attempt to compensate for such underpayments by charging other payers more, particularly private insurers. Such "cost-shifting" is not unique to hospitals in the District; it is a common practice throughout the country. Despite cost shifting, however, hospitals still incur costs, categorized as both bad debt and charity care, that remain uncompensated.

Medicaid is an important source of revenue for hospitals in the District. 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. To secure and maintain enrollment in Medicaid, the applicant must complete an application and provide all required documentation.

Eligibility determinations for Medicaid benefits in the District are made by the Income Maintenance Administration (IMA) within the Department of Human Services. Ten decentralized IMA service centers (welfare offices) receive and process applications for a range of means-tested welfare programs, including Aid to Families With Dependent Children (AFDC), Medicaid, and other programs.

[1]Medicare is a non-means-tested federal health insurance program covering most persons over age 65 and some disabled persons under age 65. Medicaid is a federal/state means-tested entitlement program of health insurance for certain low-income persons.

Results in Brief

Most hospitals in the District of Columbia do not receive all Medicaid revenues to which they may be entitled. Several hospitals incur an unnecessarily high level of uncompensated care because many uninsured patients meet the eligibility criteria for Medicaid but are not enrolled, so the hospital cannot bill the program for the care provided. Many Medicaid applicants are either unable or unwilling to complete the enrollment process without substantial assistance, yet efforts by the District government to improve eligibility system performance and increase the enrollment of hospital patients are limited.

Uncompensated care costs are a significant financial burden for many hospitals in the District. In 1990, the average uncompensated care burden (uncompensated care costs as a percentage of total operating costs) for District hospitals was 10.6 percent. This is more than twice the burden faced by hospitals nationwide, which averaged 4.7 percent in 1990. Furthermore, in recent years the ability of District hospitals to manage uncompensated care costs has diminished due to a shift in the type of insurance held by patients, an overall decline in most hospitals' financial stability, and hospitals' inability to deny emergency care to growing numbers of uninsured patients.

As the problem of uncompensated care has increased for hospitals in the District, Medicaid has grown in importance as a revenue source. To secure Medicaid reimbursement and minimize uncompensated care costs, most District hospitals contract with private firms to help their uninsured Medicaid-eligible patients enroll in the Medicaid program. The hospitals pay these firms substantial fees. Many hospital officials believe purchasing such services would not be necessary if the District government provided more direct assistance that many Medicaid applicants need to complete the enrollment process.

A number of factors contribute to the failure of qualified patients to establish Medicaid eligibility and to the need for hospitals to contract with private firms. Key factors include (1) a long, complex Medicaid application process; (2) a lack of meaningful incentives for many patients to comply with application requirements; and (3) a social services system that is under significant stress due to federal eligibility mandates for the Medicaid program, rising welfare caseloads, and chronic shortages of front-line eligibility staff.

Principal Findings

Uncompensated Care Is a Growing Problem for Hospitals

The cost of hospital uncompensated care in the District was $228 million in 1990—an increase of 45 percent since 1987. At 10.6 percent of operating costs in 1990, the average uncompensated care burden of District hospitals was nearly twice that faced by hospitals nationwide. At a number of hospitals, the burden of uncompensated care has grown rapidly. At D.C. General Hospital, for example, the uncompensated care burden increased from 6.4 percent in 1987 to 15.5 percent in 1990, while at Howard University Hospital, it increased from 10.0 to 21.2 percent. [2]

Shifting the cost of uncompensated care to those with insurance has become a less effective financial management strategy for hospitals in the District because the insurance coverage held by hospital patients has shifted over the past several years. The group of patients insured by payers to whom costs can easily be shifted (those insured by commercial full charge plans) remains relatively small at about one-fourth of all insured patients in the District, while more patients are insured by commercial discount plans, Medicaid, and Medicare. [3] From the hospitals' perspective, the shift has been from insurers willing to pay full charges to those who pay only a percentage of hospital charges along with an increasing number of uninsured patients.

The percentage of hospital patients in the District with no identified source of payment has nearly doubled in recent years, increasing from 7.5 percent in 1985 to 13.9 percent in 1990. In addition, District hospitals are constrained in their ability to control uncompensated care because they are required by federal law to provide emergency services to all patients who need care, regardless of their ability to pay. [4] A 1988 DCHA

[2]D.C. General and Howard University hospitals receive subsidies from the District and federal governments, respectively, that are applied toward uncompensated care. In 1990, D.C. General received a subsidy of nearly $50 million from the District government. In the absence of this subsidy, the uncompensated care burden at D.C. General would have been 55.5 percent. Approximately $11.3 million of Howard University Hospital's federal subsidy was applied toward uncompensated care in 1990. Without its subsidy, Howard's uncompensated care burden would have been 28.6 percent.

[3]Charges are the dollar amount requested by health care providers for the provision of services, while costs are the actual dollar amount incurred in the provision of services. In general, full-charge plans reimburse the provider at the full charge requested, while discount plans reimburse the provider at a lower negotiated rate. Medicaid provides a reimbursement rate that is set by each state.

[4]42 U.S.C. 1395(dd).

survey showed that 83 percent of uninsured patients admitted to District hospitals were admitted on an emergency basis. [5]

With fewer sources paying full charges—including Medicaid, Medicare, and many private insurers—hospital operating margins are declining. Operating margins, which represent the difference between revenues and expenses, are a primary measure of a hospital's financial health. Although 4 hospitals in the District saw their operating margins improve slightly between 1985 and 1990, the remainder experienced declines. The average operating margin for hospitals in the District declined from +4.6 percent in 1985 to –4.9 percent in 1990. Hospital operating margins also declined nationwide, but not as drastically as in the District. These trends reflect an increasingly fragile financial condition that has left many hospitals less able to manage their growing volumes of uncompensated care. [6]

Hospitals Do Not Receive All Medicaid Revenues to Which They May Be Entitled

Most hospitals in the District of Columbia experience difficulty receiving all Medicaid revenues to which they may be entitled. The 1988 DCHA survey estimated that 17 percent of uninsured hospital patients in the District were eligible for Medicaid but not enrolled. In 1990, nearly 14 percent of all patients admitted to District hospitals did not have any form of insurance. Some of these patients were eligible for Medicaid. Hospital officials estimated that they are able to enroll only one-third of the uninsured patients they identify as Medicaid-eligible at the time of admission. With no other identified source of payment, those who did not secure enrollment in Medicaid are very likely to generate uncompensated care.

Ten hospitals in the District currently contract with one of two national financial management consulting firms, referred to as enrollment vendor firms, to guide their patients though the Medicaid application process. These firms provide a variety of services to patients, including helping them to understand the Medicaid application, assemble proper documentation, arrange transportation to and from the District welfare offices, and deliver completed application packages to District eligibility workers. Their success in securing Medicaid enrollment for patients

[5]District of Columbia Hospital Association Prospective Uninsured Patient Survey, Lewin/ICF, 1988.

[6]New data provided by DCHA just before publication of this report cover the year 1991. The financial position of hospitals in the District improved somewhat during this most recent year. The total volume of uncompensated care provided by District hospitals was $201 million in 1991, down from $228 million in 1990. Operating margins also improved, but still remained negative overall at –0.31 percent.

referred to them ranges from 30 to 85 percent across hospitals. [7] The vendor firms attribute their ability to secure enrollment for patients to specialization, a field work capability that neither the hospitals nor the District government possesses, and a payment system that rewards the vendor only for successful enrollment of applicants.

These private firms work on a contingency fee basis; they are paid only for cases in which patients become enrolled. The cost to hospitals in the District ranges from $350 to $1,250 per case. This amount represents from 7 to 17 percent of hospitals' Medicaid reimbursement per discharge. [8] Under the Medicaid reimbursement system in the District, hospitals are not generally able to recover the additional costs incurred for employment of the vendor firms. Hospitals would not have to rely on these firms so extensively if the Medicaid eligibility process in the District was less burdensome and complex and more responsive to applicants' need for assistance.

The Long, Complex Application Process Poses Barriers to Medicaid Enrollment

The application form for Medicaid in the District is 10 pages long and designed to solicit information on a wide range of eligibility factors. Applicants must support and verify that the information they supply on the form is accurate. (Appendixes V and VI contain copies of the Medicaid application and documentation requirements.) The amount of information requested on the form and the extensive documentation and verification standards required for Medicaid enrollment exist primarily as a quality control mechanism to ensure that only those truly eligible are certified. Federal oversight of the Medicaid eligibility process focuses primarily on enrollment and claims payment accuracy because as Medicaid is a means-tested welfare program, there is a concern that funds go only to those in need. The District government faces the loss of a portion of its federal Medicaid funds if enrollment and claims payment error rates exceed specified thresholds.

Many Medicaid applicants face neither meaningful incentives for complying with application requirements nor sanctions for not complying. Since federal law requires most hospitals to provide emergency care to all

[7]The terms of contracts with vendor firms differ across hospitals. Some hospitals refer all potential Medicaid patients to the vendor, while others refer only a small percentage of the more "difficult" cases—those in which the patient is unable or unwilling to complete the Medicaid application and appears unlikely to follow through with the full enrollment process.

[8]Except for the Hospital for Sick Children and the National Rehabilitation Hospital, which are reimbursed on a per diem basis, each hospital has a set per discharge Medicaid reimbursement rate that does not vary by a patient's diagnosis or length of stay. This rate ranged from $2,395 to $8,465 per discharge for District hospitals in fiscal year 1990.

patients who present themselves regardless of their ability to pay, an individual's failure to establish Medicaid eligibility does not restrict their access to this care. Many potential beneficiaries are unable or unwilling to submit an initial application or to comply with extensive documentation requirements. They must often invest substantial time and effort to obtain and return all necessary documentation in order for an application to be processed. In addition, literacy and language difficulties may pose significant barriers for some applicants.

Applicants who are unable or unwilling to meet documentation requirements are denied eligibility for failure to comply with procedural requirements. A failure to comply with procedural requirements could mean that applicants missed appointments with eligibility workers, that income verification was not sent in, or that the correct number of verification documents were not collected or submitted. Some applicants have no family members or friends who can help them obtain needed documents and verifications, and some do not understand the importance of following through with the application process and do not respond to agency requests for additional information. One HCFA official expressed concern that documentation and verification standards may be driving individuals to drop out of the application process and encouraging wrongful or inappropriate denial of benefits.

Insufficient Resources Directed by the District to the Complex Eligibility Determination Process

At a time when the enrollment process has grown more complex to administer as a result of numerous federal mandates and policy changes, the District government has devoted fewer resources than in the past to performing eligibility determinations for the Medicaid program. Eligibility for Medicaid is tied to many factors beyond an individual's ability to pay for health care. District eligibility workers must be familiar with numerous eligibility categories, multiple income scales, and as many as 129 program eligibility codes. Unlike eligibility determinations for other means-tested welfare programs in the District, Medicaid eligibility determinations are largely performed manually. Automating the process has been difficult because of the complexity of the program's categories and eligibility rules.

Although the District's welfare system is faced with steadily rising caseloads for its major public assistance programs, the number of welfare eligibility workers has declined. From 1988 to 1991, Medicaid enrollment in the District increased by 21 percent; the AFDC caseload increased by 14 percent; and the number of households issued Food Stamps increased by 28 percent. During approximately the same period, IMA staffing for

eligibility determinations declined by 17 percent and turnover averaged 13 percent per year. In addition, from 1989 to 1991, vacancies among eligibility workers increased by 64 percent—from 69 to 113 workers. Inadequate staffing levels were the primary operational reason cited by patient advocates and District government officials why many applicants for Medicaid are not able to secure sufficient assistance to complete the application process.

District's Efforts to Increase Medicaid Enrollment Are Modest

To reduce documentation requirements for applicants as well as improve eligibility worker productivity, the District government is implementing a new automated eligibility system for the AFDC, Food Stamp, and Medicaid programs. Pilot testing for this new system began in July 1992, but full implementation is not scheduled until August 1993. In addition, the District government has established a central Medicaid intake unit specifically to serve as a focal point for hospitals and to receive Medicaid applications for hospital inpatients. However, this unit is not available to serve all hospitals in the District, staffing was recently reduced, and eligibility worker caseloads have increased sharply.

Most applications received by the hospital unit are denied Medicaid eligibility for applicant failure to comply with procedural requirements. Of 3,311 applications received from hospitals and vendor firms during a 9-month period of 1991, 2,274 (69 percent) were denied eligibility. Eighty-six percent of these denials were for failure to comply with procedural requirements. About two-thirds of all applications received by the hospital unit are for patients at D.C. General, the District government's public hospital. For applicants from D.C. General, procedural denials account for more than 90 percent of all denials. Failure to secure Medicaid enrollment for eligible D.C. General patients means that the District government does not receive the 50 percent federal match under Medicaid and must assume the full cost of providing care to these patients if no other source of payment is available. With a Medicaid reimbursement rate of $5,275 per patient at D.C. General in 1991, the District government forgoes over $2,600 in federal funds for every Medicaid-eligible patient at D.C. General who is not enrolled.

Officials at most hospitals in the District believe that placing an eligibility worker on site at the hospital would help them to enroll eligible patients in the Medicaid program and secure more Medicaid revenues. The experiences of numerous states suggest that such activities can be successful. In addition, recently enacted federal legislation contains

requirements for states to provide outreach to certain Medicaid applicants in hospitals and other settings beyond the welfare office. [9] Such outreach may include placing eligibility workers in hospitals. However, District eligibility workers have thus far been placed in only one hospital, and no expansion of this approach is planned. Staffing considerations were the primary justification given by District officials for not expanding these efforts.

Conclusions

Medicaid revenues are only one part of District hospitals' overall financial picture, yet clearly the issue of Medicaid nonenrollment has negative financial implications for most hospitals and, in the case of D.C. General, for the District government as well. Hospitals are relying on vendor firms to facilitate Medicaid enrollment for eligible patients at a time when the financial position of many hospitals is increasingly strained, and their ability to effectively manage growing numbers of uninsured patients and a growing volume of uncompensated care is greatly reduced. Because most hospitals must provide emergency care to all persons regardless of their ability to pay, the fact that a Medicaid-eligible patient is not enrolled does not impede that person's access to care, only the hospital's ability to receive payment from Medicaid for providing the care.

The Medicaid program is designed to facilitate access to health care by providing certain needy persons with a source of payment. However, because it is a means-tested welfare program, states and the District of Columbia are held to strict standards of accountability. The federal Medicaid eligibility quality control system is designed to ensure that public funds are not spent to provide benefits to individuals who do not meet the program's eligibility criteria. As such, within the Medicaid program, there is an inherent trade-off between the social policy goal of access to care and the fiscal policy goal of financial accountability. Greater accountability, in the form of additional documentation and verification requirements, works against the interests of individuals concerned with access to care and providers concerned with maximizing Medicaid revenues. However, providing easier access to Medicaid benefits, by reducing eligibility requirements for applicants and program staff, may work against the accountability principles of Medicaid as a means-tested welfare program. It is up to the states and the District government to balance these competing goals.

[9] "Mandatory Use of Outreach Locations Other Than Welfare Offices," Omnibus Budget Reconciliation Act of 1990. Social Security Act, Section 1902(a)(55). 42 U.S.C. 1396a(a)(55).

A number of interrelated operational, applicant, and policy-related factors account for why many Medicaid-eligible hospital patients in the District neither are enrolled in Medicaid at the time of their admission nor become enrolled later to cover the costs of their hospital stay. The District government has control over staffing levels, training, and placement of eligibility workers, but there are many factors related to eligibility and enrollment over which the District government has little control. These include (1) the growing complexity of eligibility rules and categories resulting from federal mandates for program expansion; (2) the need for a long application form and extensive documentation driven by federal quality control standards; and (3) few meaningful incentives for many hospital patients to undergo the long, complex application process.

Although not all factors related to Medicaid eligibility are within the District government's control, some of the enrollment barriers for hospital patients identified in this study clearly warrant greater attention by the District. Of particular concern to District officials should be the Medicaid enrollment of patients at D.C. General hospital given that (1) there is a high rate of incomplete Medicaid applications and procedural denials of eligibility for applications received from D.C. General and other hospitals; (2) the District government subsidizes more than $50 million annually in uncompensated care at D.C. General; and (3) the District forgoes over $2,600 in federal funds for each indigent nonenrolled Medicaid-eligible inpatient served at D.C. General.

Recommendation

We recommend that the Mayor of the District of Columbia establish a demonstration or pilot project focusing on the enrollment of Medicaid-eligible individuals at hospitals. Such a project could (1) identify and describe the population or subpopulations of eligible patients having the most difficulty getting enrolled; (2) identify the assistance needs of these groups; and (3) test methods of providing these patients with needed assistance through outstationing of eligibility workers and other means.

We discussed a draft of this report with officials of the District of Columbia government, HCFA, and the District of Columbia Hospital Association. HCFA and District government officials generally agreed with our conclusions and the desirability of establishing a demonstration or pilot project. We have incorporated their comments as appropriate. 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 Health and Human Services, the Administrator of the Health Care Financing Administration, the Mayor of the District of Columbia, and other interested parties.

Please contact me on (202) 512-7119 if you have any questions. Major contributors are listed in appendix VII.

Janet L. Shikles

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Figures

Abbreviations

AFDC	Aid to Families With Dependent Children
DCHA	District of Columbia Hospital Association
HCFA	Health Care Financing Administration
IMA	Income Maintenance Administration
SSI	Supplemental Security Income

Hospitals in the District of Columbia Included in GAO Review

There are 13 nonfederal, nonpsychiatric hospitals operating in the District of Columbia that participate in the Medicaid program. [1] Information about hospital finances and patient characteristics was obtained in three ways: (1) structured interviews with hospital officials; (2) data requests sent to individual hospitals; and (3) data provided by the District of Columbia Hospital Association (DCHA). Hospitals we included are shown in figure I.1.

Figure I.1: District Hospitals Included in Review

Facility		Interview	Data Request	DCHA Data
1	Capitol Hill Hospital	□	□	○
2	Children's Hospital	○	○	○
3	Columbia Hospital	○	○	○
4	D.C. General Hospital	○	○	○
5	GWU Medical Center	○	○	○
6	Georgetown U. Hospital	○	○	○
7	Greater Southeast Hospital	○	○	○
8	Hadley Memorial Hospital	○	○	○
9	Hospital for Sick Children	○	○	○
10	Howard University Hospital	○	○	○
11	Providence Hospital	○	○	○
12	National Rehabilitation Hospital	○	○	○
13	Sibley Memorial Hospital	●	○	○
14	Washington Hospital Center	○	○	○
Totals		**12/14**	**13/14**	**14/14**

□ Not Available
● Declined to be interviewed
○ Responded

[1]Capitol Hill Hospital ceased operations in 1991, before we began this study. Officials of Sibley Memorial Hospital declined to be interviewed.

Uncompensated Care Is a Growing Problem for Hospitals in the District of Columbia

Uncompensated care costs are a significant financial burden for many hospitals in the District of Columbia. In 1990 the average uncompensated care burden for hospitals in the District was more than twice that faced by hospitals nationwide. Furthermore, District hospitals are decreasingly able to manage their uncompensated care burden due to a shift in type of insurance coverage held by patients, an overall decline in financial stability, and an inability to deny emergency care to uninsured patients.

Background

Uncompensated care is the cost incurred by a hospital of services rendered to patients for which the hospital does not receive payment. Uncompensated care may be provided deliberately (charity care) or unintentionally (bad debt). [1] 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. Some insurance plans do not cover a full range of health care services or may require high cost sharing. However, not all uninsured patients generate uncompensated care; some are able to pay their hospital bills in full.

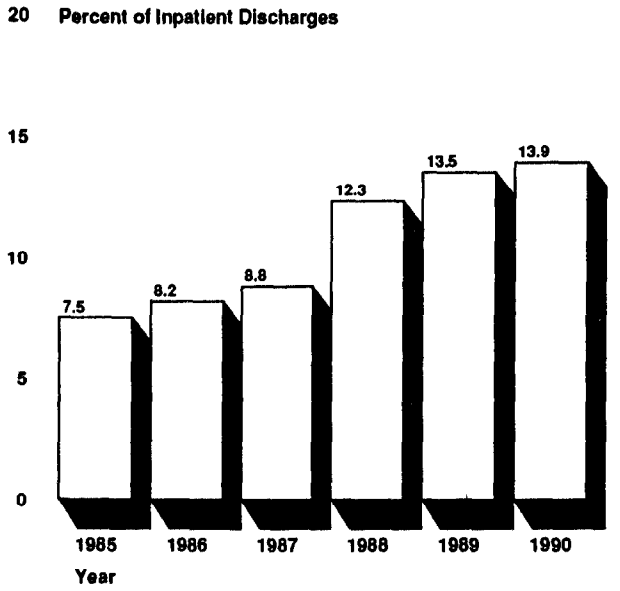
Hospitals Face Significant Uncompensated Care Burden

Uncompensated care costs for most District hospitals are well above the national average. In the District, uncompensated care accounted for 10.6 percent of hospital operating costs in 1990, while uncompensated care nationwide represented 4.7 percent of operating costs. From 1987 to 1990, the total cost of hospital uncompensated care in the District increased by 45 percent—from $157 million to $228 million. [2] The number of uninsured hospital patients in the District has more than doubled from about 11,500 in 1985 to almost 25,000 in 1990, representing an increase of from 7.5 percent to 13.9 percent of all discharges, as shown in figure II.1.

[1]Bad debt refers to uncollectible billed charges. Charity care refers to an estimate of the amount that would have been billed for services rendered to patients deemed unable to pay; since the hospital does not expect payment, these charges are not billed.

[2]Excludes federal and psychiatric hospitals.

Figure II.1: Uninsured Hospital Patients in the District (1985-90)



A study published by the Prospective Payment Assessment Commission showed that of the nation's 20 largest cities, hospitals in Washington, D.C., had the highest average uncompensated care rate at 6.8 percent from 1984 to 1989. [3] This is considerably higher than uncompensated care costs nationwide, which averaged 4.7 percent during the same period. [4] In 1990 average hospital uncompensated care costs nationwide remained at 4.7 percent, while in the District they increased to 10.6 percent. [5]

Uncompensated care costs differ significantly across District hospitals. In 1990, uncompensated care burdens for hospitals in the District ranged from 1.2 percent to 21.2 percent of hospital operating costs, as shown in figure II.2. Uncompensated care was highest at Howard University

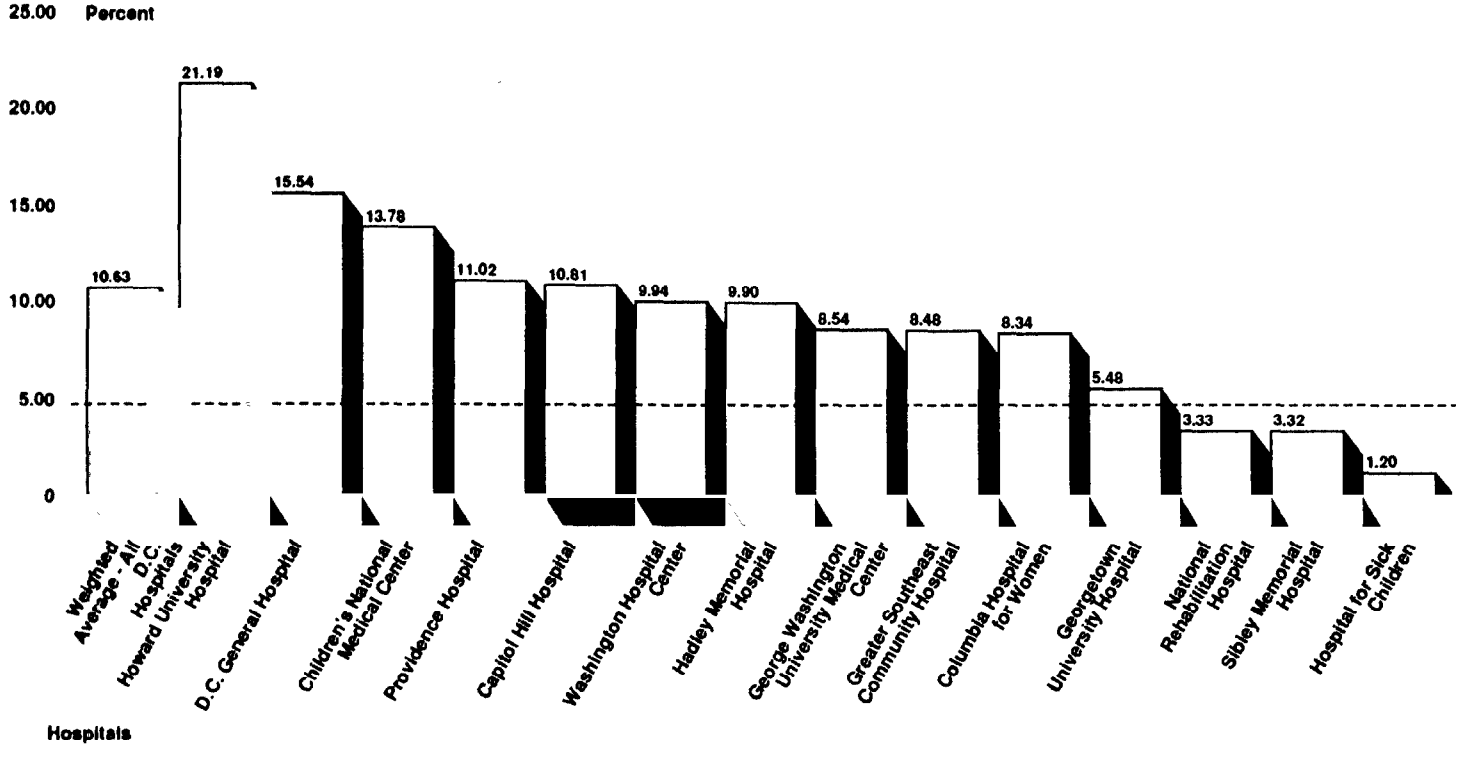
[3]Jack Ashby, The Trend and Distribution of Hospital Uncompensated Care Costs, 1980-1989, Technical Report I-91-04, Prospective Payment Assessment Commission, October 1991.

[4]GAO calculation from unpublished American Hospital Association data.

[5]Unpublished District of Columbia Hospital Association data.

Hospital (21.2 percent) and D.C. General Hospital (15.5 percent). [6] These two hospitals also experienced the most significant increases in uncompensated care costs. The uncompensated care burden at D.C. General more than doubled from 1987 to 1990, rising from 6.4 percent of hospital operating costs to 15.5 percent. At Howard, uncompensated care increased from 10.0 percent to 21.2 percent.

Figure II.2: Uncompensated Care Burden by Hospital (1990)



----- National Average is 4.7 percent (Source: AHA)

Notes:

1. Hospital uncompensated care burden equals uncompensated care costs, net of government subsidies, divided by total operating expenses.
2. District of Columbia data provided by the D.C. Hospital Association.

[6]Both hospitals receive annual government subsidies that are applied toward their uncompensated care costs. For example, in 1990, D.C. General, the acute care public hospital in the District, received a subsidy payment of nearly $50 million from the District government. All of D.C. General's subsidy is applied to its uncompensated care costs. Without the subsidy, D.C. General's uncompensated care burden would have been 55.5 percent of operating costs. Howard University Hospital receives an annual subsidy from the federal government, part of which is applied to uncompensated care costs; about $11.3 million of the annual subsidy was applied toward such costs in fiscal year 1990. Without this subsidy, Howard's uncompensated care burden would have been 28.6 percent of operating costs.

Hospitals Less Able to Effectively Manage Uncompensated Care

Faced with increasing uncompensated care costs, hospital officials can attempt to (1) absorb the costs of such care; (2) shift the costs of such care to paying patients; (3) deny services to patients unable to pay; or (4) improve collection of bad debts. In recent years the ability of hospitals in the District to pursue most of these options for managing their uncompensated care has diminished due to an overall decline in most hospitals' financial stability, an increase in the percentage of patients insured by discount insurance plans and government payers, and hospitals' inability to deny emergency care to growing numbers of uninsured patients.

Hospitals in strong financial condition are in a better position to absorb uncompensated care costs. In the District, however, hospital operating margins (the percentage difference between operating expenses and operating revenues) have been declining. The declining operating margins are a concern to hospital and city officials because they are a primary measure of a hospital's economic status and, as such, reflect increasingly fragile financial condition.

The Prospective Payment Assessment Commission reported that nationwide, hospital operating margins declined from 6.5 percent in 1985 to 3.8 percent in 1989. [7] The average operating margin for hospitals in the District has declined even more precipitously, dropping from +4.6 percent in 1985 to –4.9 percent in 1990. Although a few hospitals in the District saw their operating margins improve slightly over the 6-year period, most experienced declining operating margins. [8]

A second management strategy used by District hospitals, as well as hospitals nationwide, has been to rely on "cost shifting" as a means of distributing the costs of uncompensated care among all paying patients. In essence, the cost of uncompensated care is divided among insured patients, and the charge for their care increased accordingly. This strategy succeeds as long as enough paying patients remain to assume the additional charges without placing too high a financial burden on any one group.

[7] Medicare and the American Health Care System, Prospective Payment Assessment Commission, June 1991.

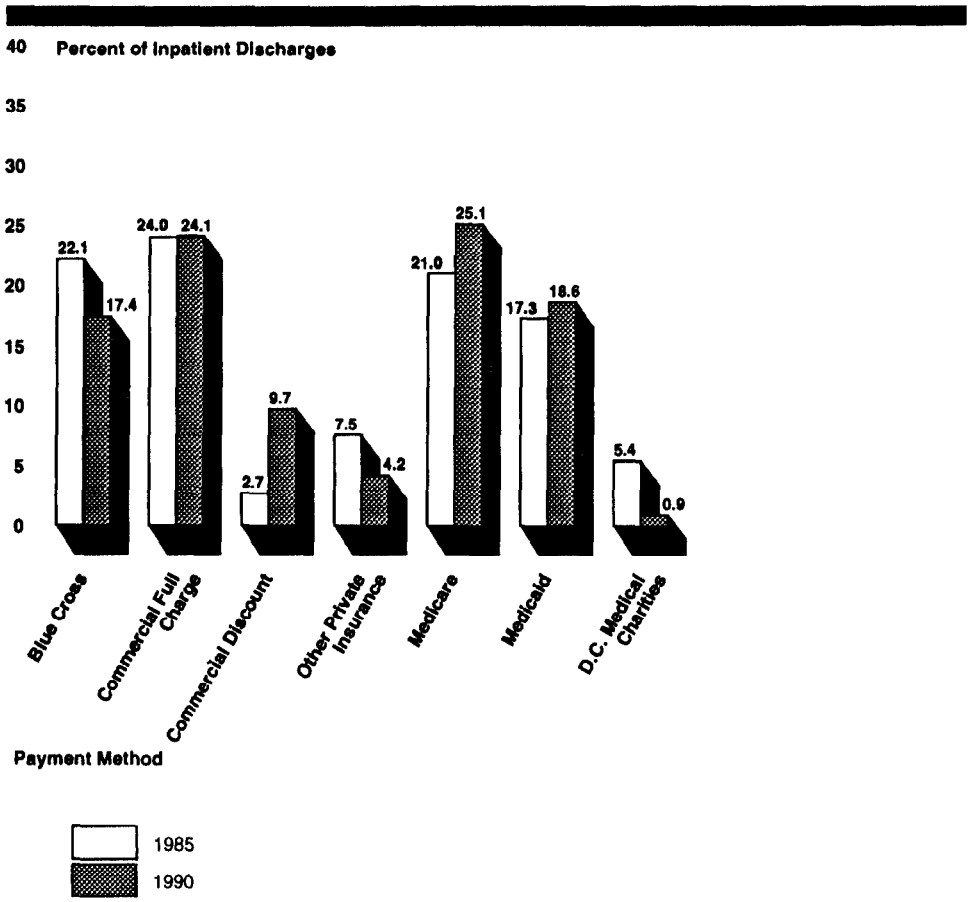
[8] New data provided by DCHA just before publication of this report cover the year 1991. The financial position of hospitals in the District improved somewhat during this most recent year. The total volume of uncompensated care provided by District hospitals was $201 million in 1991, down from $228 million in 1990. Operating margins also improved, but still remained negative overall at –0.31 percent.

As the number of uninsured and the cost of providing hospital care have grown, insurers have become less willing to pay full charges. [9] Government payers have set specific reimbursement rates, and some commercial payers, such as managed care plans, have negotiated discount reimbursement rates.

The group of patients insured by payers to whom costs can easily be shifted (those insured by commercial full charge plans) remains relatively small and constant at about one-fourth of all insured patients. Blue Cross, a discount noncommercial insurer, covered 22.1 percent of paying patients in 1985 and dropped to 17.4 percent in 1990. The percentage of patients insured by commercial discount plans increased over this period from 2.7 to 9.7 percent of all patients with an identified source of payment. Medicaid was identified as the payer source for 17.3 percent of patients in 1985 and 18.6 percent in 1990, while the percentage insured by Medicare increased from 21.0 to 25.1 percent. The payer mix is shown in figure II.3. From the hospitals' perspective, the large number of patients insured by payers that pay only a percentage of hospital charges has contributed to the decline in hospital revenues.

[9]Charges are the dollar amount requested by health care providers for providing services, while costs are the actual dollar amount incurred in providing services. Under a full-charge plan, an insurer pays the provider at the full charge requested. Under a discount plan, the insurer negotiates with the provider to settle at a reimbursement rate that is lower than the full charge rate. Under Medicaid, hospital reimbursement rates are set by each state within broad federal guidelines.

Figure II.3: Percent Shift in Payer Mix, D.C. Hospitals (1985-90)



Notes:

1. Chart includes only patients with insurance.
2. Percents may not add to 100 due to rounding.

Finally, hospitals are constrained in their ability to control their uncompensated care costs due to legislative mandates. All Medicare-certified acute care hospitals with emergency departments are required by federal law to provide emergency services to all patients who need care, regardless of ability to pay. [10] A 1988 DCHA survey showed that 83 percent of

[10]Social Security Act, Section 1867; 42 U.S.C. 1395(dd).

uninsured patients admitted to hospitals in the District were admitted on an emergency basis. [11]

[11]District of Columbia Hospital Association Prospective Uninsured Patient Survey, Lewin/ICF, 1988.

District of Columbia Hospitals Are Not Receiving All Medicaid Revenues to Which They May Be Entitled

With fewer patients able to pay for their hospital care, and hospitals less able to pass these costs on to other patients, Medicaid has grown in importance as a revenue source for hospitals in the District. At the same time, however, most District hospitals experience difficulty receiving all Medicaid revenues to which they may be entitled. Many uninsured patients who receive services at District hospitals meet the eligibility criteria for Medicaid but are not enrolled, preventing the hospitals from billing Medicaid for the care provided. With no form of payment other than "self-pay," those who do not enroll in Medicaid are likely to generate uncompensated care. To receive Medicaid reimbursement and minimize uncompensated care costs, District hospitals contract with private firms that help patients through the Medicaid application process.

Background

The Medicaid program was established in 1965 as a means-tested entitlement program of medical assistance for certain low-income persons. Medicaid is funded jointly by both the federal and state governments, but is administered at the state level, and states are given a great deal of flexibility to determine such program issues as services covered, provider reimbursement, and eligibility criteria. Eligibility for Medicaid has traditionally been linked to actual or potential receipt of cash welfare assistance under the Aid to Families With Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. In order for hospitals and other providers to bill the Medicaid program for services provided, patients must either be enrolled in Medicaid at the time of admission or complete the application and enrollment process within a limited time after their treatment. If a Medicaid application is completed and filed with the District government within 90 days of a patient's admission, eligibility can be granted retroactively to cover the period of hospitalization.

Some Uninsured Hospital Patients That Are Eligible for Medicaid Are Not Enrolled

At admission, hospital patients are screened for a source of payment. Those without any form of insurance are categorized as "self-pay" and evaluated for potential Medicaid eligibility. If the hospital officials determine that a patient is likely to be eligible for Medicaid, an application is initiated. However, not all patients identified as potentially eligible for Medicaid were enrolled during or shortly after their hospital stay. A 1988 study estimated that 17 percent of uninsured patients admitted to hospitals in the District were eligible for Medicaid at the time of admission. [1] Overall, hospital officials estimate that they are successful in gaining enrollment

[1]District of Columbia Hospital Association Prospective Uninsured Patient Survey, Lewin/ICF, 1988.

for only one-third of the uninsured patients identified at the time of admission as potentially eligible for Medicaid. [2] However, the reported enrollment rate varies by hospital. For example, the enrollment rate was 12 percent at D.C. General, 65 percent at Washington Hospital Center, and 88 percent at the National Rehabilitation Hospital.

Hospitals Use Private Contractors to Enroll Eligible Patients in Medicaid

Concerned about a large number of Medicaid-eligible patients who are not securing enrollment, thus generating uncompensated care, almost all hospitals participating in the District's Medicaid program contract with one of two national financial management consulting firms, referred to here as enrollment vendor firms, to guide their inpatients through the Medicaid application process. Hospitals pay these firms substantial fees to perform services that some hospital officials believe would not be necessary if the Medicaid enrollment process in the District were less burdensome and complex and more responsive to applicants' need for "hands-on" assistance.

The enrollment vendor firm's initial contact with a patient may be as early as soon after admission, or as late as after discharge from the hospital, depending on the agreement between the firm and the hospital. After a patient has been identified as potentially eligible for Medicaid, the enrollment vendor firm helps the patient complete and process the necessary application forms.

These vendor firms provide a wide range of services, including helping patients understand the application, assemble proper documentation, arrange transportation, and deliver completed application packages to District eligibility workers. The specific services provided may vary according to the applicant's needs. The firms provide significant assistance to applicants in the assembling of supporting documentation, which may include birth certificates, social security cards, rent receipts, bank statements, and wage and salary statements. Patients who do not understand what documents are needed or how to obtain them are given information. The firms provide transportation as necessary, and they may pay any fees needed to obtain the required documentation.

The vendor firms also monitor the processing of completed applications. For example, they may take the completed applications and supporting documentation to a Medicaid service center for processing and follow-up

[2]Due to data limitations, it was not possible to independently determine the exact number of District hospital patients who were eligible for Medicaid but did not enroll, nor was it possible to determine the exact amount of uncompensated care generated by these patients.

with the assigned caseworker to ensure prompt consideration. If an applicant interview is required, the firms may provide transportation to the service center for the interview.

The terms of the financial contracts between the enrollment vendor firms and the hospitals vary. The firms work on a contingency fee basis; some are paid when enrollment in Medicaid is completed, while others are paid only when the hospital receives reimbursement from Medicaid. The cost to hospitals for Medicaid enrollment services ranged from about $350 to $1,250 per case in 1990. Given that the District's Medicaid program reimburses most hospitals on a flat-rate, per discharge basis, these contractor fees range from 7 to 17 percent of the hospitals' Medicaid reimbursement per discharge. These firms' success at enrolling patients in Medicaid ranges from 30 to 85 percent. [3] The firms attribute their success rates to specialization, a field work capability that neither the hospitals nor the District government possesses, and a payment system that rewards the vendor only for successful enrollments.

Some hospitals have expressed concern about the cost of employing these firms and have indicated they would like to reduce their use of them. Many hospital officials believe these private vendor firm contracts should not be necessary because either (1) the District's Medicaid program should be designed so that applicants can complete the application process without professional assistance or (2) the District government should provide sufficient resources to ensure that applicants are given the help needed to enroll.

[3]The terms of contracts with vendor firms vary across hospitals. Some hospitals refer all potential Medicaid patients to the firm, while others refer only a small percentage of the more "difficult" cases—those in which the patient is unable or unwilling to complete the Medicaid application and appears unlikely to follow through with the full enrollment process.

Multiple Barriers to Medicaid Enrollment Exist in the District of Columbia

Multiple barriers to Medicaid enrollment exist in the District of Columbia, contributing to the need for hospitals to contract with enrollment vendor firms. Principal among these are (1) a long, complex Medicaid application process; (2) a lack of meaningful incentives for many uninsured hospital patients to comply with application requirements; and (3) a social services system that is under significant stress due to the increasing complexity of the Medicaid enrollment process, rising welfare caseloads, and chronic shortages of front-line eligibility staff. Although many Medicaid applicants are either unable or unwilling to complete the enrollment process without substantial assistance, efforts by the District government to improve eligibility system performance and increase the enrollment of hospital patients have been modest.

Background

In the District, responsibility for the Medicaid program is divided between the Commission on Health Care Finance and the Income Maintenance Administration (IMA). Both are part of the District of Columbia Department of Human Services. As the designated Medicaid agency, the Commission on Health Care Finance has primary responsibility for administering the Medicaid program in the District. Its responsibilities include provider certification, claims processing, review and inspection of facilities providing care, and maintenance of program integrity.

Responsibility for the operations of Medicaid eligibility is assigned to IMA. The Commission on Social Services and IMA develop policies, procedures, and forms to implement federal and District Medicaid eligibility regulations. IMA operates 10 service centers (welfare offices) in the District, where applications for Medicaid, AFDC, and other public assistance benefits are processed.

The District government uses separate application forms for AFDC and for Medicaid-only assistance. AFDC and Medicaid applications may be obtained at any of the District welfare offices. In addition, Medicaid application forms are available at hospitals and public health clinics. The Medicaid application form is 10 pages long and is designed to solicit applicant information on the various eligibility factors. (A copy of the District Medicaid application is provided as appendix V.) In addition to completing this form, Medicaid applicants must complete a "Citizenship and Alienage Declaration" form and an "Authorization for Investigations" form in order for the application to be processed.

Eligibility workers review each application for internal consistency. The statements of income and expenses must appear reasonable and be supported by appropriate documentation. Applicants must support and verify that the information they supply on the form is accurate. (Appendix VI shows the documentation and verification requirements for District Medicaid applicants.)

The Long, Complex Application Process Poses Barriers to Medicaid Enrollment in the District

For many applicants, the length of the application form and extensive documentation required pose significant barriers to enrollment. Without substantial assistance or encouragement, many potentially eligible persons lack sufficient ability or meaningful incentives to comply with the extensive procedural requirements for enrollment. In addition, the application and enrollment process for Medicaid in the District has become increasingly complex for program staff due in part to numerous federal mandates and policy changes.

Extensive Documentation Requirements and Long Application Form Cited as Barriers to Enrollment

For applicants, the length of the application form and extensive documentation required were cited by Medicaid officials and hospital association representatives as significant barriers to enrollment in the District. These requirements were developed in response to requirements of the federal Medicaid quality control system. The District government faces a loss of a portion of its federal matching funds for Medicaid if enrollment and claims payment error rates exceed federally specified thresholds. Federal oversight of eligibility focuses primarily on enrollment and claims payment accuracy because Medicaid is a means-tested welfare program.

To complete the application process for AFDC or Medicaid on their own, applicants must possess (1) the ability to read, write, and comprehend complicated instructions regarding documentation, time requirements, rights, and responsibilities; (2) sufficient time and transportation during daytime hours to obtain documents from public agencies, current and former employers, health providers, landlords, and others; (3) money to pay for official documents, postage, copies, and certain medical tests required for verification purposes; (4) access to a telephone and a copying machine; and (5) in most cases, the ability during daytime hours to be at a welfare office to complete a personal interview.

According to HCFA officials, the amount of information requested on the application and the documentation and verification standards that must be

met exist primarily as a quality control mechanism to ensure that only those truly eligible are certified. Documentation standards are set high due to concern for potential financial penalties if enrollment and payment error rates for Medicaid exceed federally specified thresholds. [1]

Patient advocates in the District have stated that because the District government has been subject to federal sanctions for excessive error rates in the past, the government is careful to ensure that it only enrolls those truly eligible. Applicants who are unable or unwilling to meet documentation requirements are denied eligibility for failure to comply with procedural requirements. [2] One HCFA official expressed concern that documentation and verification standards may be driving individuals to drop out of the application process and encouraging wrongful or inappropriate denial of benefits. He cited research that concluded that a significant proportion of procedural denials of eligibility were due to stringent state requirements for documentation and applicants' inability to comply with requirements. [3] A failure to comply with procedural requirements could mean that applicants missed appointments with eligibility workers, that income verification was not sent in, or that the right number of verification documents was not collected or submitted.

In a limited recent analysis of 3 months of Medicaid applications submitted to IMA by hospitals and vendor firms in 1991, IMA staff found that over 50 percent of all Medicaid applications processed were denied for procedural reasons. Medicaid eligibility staff state that some of the procedural reasons that applications are denied include: (1) eligibility workers are unable to maintain lines of communication with applicants because hospital staff did not obtain correct addresses; (2) some applicants have no family members or friends who can help them obtain needed documents and verifications; and (3) some applicants do not understand the importance of following through with the application process and do not respond to agency requests for additional information.

[1]Fiscal sanctions are not applied to all errors in eligibility determination. They are applied only to agency or applicant errors when benefits are incorrectly given, not when they are inappropriately withheld. There is not currently a process in place, however, to identify and determine how many applicants may be improperly denied and for what reasons.

[2]The District Medicaid director also reported that failure to recertify eligibility is a common problem in the District. Many enrollees do not submit the necessary documentation for recertification. Officials estimate that 90 percent of lapsed eligibility is due to clients' failure to respond to recertification notices and return appropriate documentation.

[3]An Examination of the Barriers to Accessing WIC, AFDC, and Medicaid Services, Southern Governors' Association, 1989.

Some Eligible Individuals Lack Sufficient Incentives to Comply With Application Requirements

Many applicants face neither meaningful incentives for complying with application requirements nor sanctions for not complying. This is especially true for those applying only for Medicaid and not for other welfare benefits. Patient advocates in the District contend that only those who are highly motivated or are able to obtain substantial assistance are likely to complete the Medicaid enrollment process. Advocates stated that effective enrollment in the District's Medicaid program is limited primarily to two groups: (1) AFDC cash assistance applicants who have a clear financial incentive to comply with all application requirements and (2) hospital patients who receive substantial assistance and encouragement from hospitals concerned with obtaining Medicaid reimbursement and reducing their levels of uncompensated care.

As a means-tested welfare program, Medicaid carries with it a social stigma that serves as a barrier to enrollment for many potential beneficiaries, according to the District's Medicaid director. The requirement for most applicants to go to the welfare office to file their application and receive an interview was cited by hospital officials and others as a potential barrier to enrollment. This barrier may be particularly significant as changes in recent years have expanded Medicaid eligibility beyond the "traditional" welfare population that automatically qualifies for Medicaid by virtue of receiving AFDC or SSI cash assistance benefits.

Hospital representatives stressed that, for eligible patients who are not enrolled at admission to the hospital, the application process needs to be initiated while the patient is still in the hospital. After discharge, the patient is less likely to initiate or follow through with an application. Hospital officials contend that patients are often not motivated to follow through with the Medicaid application process because they know that the hospital is required to treat them in emergency situations, and hospitals have traditionally been viewed as community services that should be available to everyone. District government officials concurred with this assessment, stating that once an individual's medical problem has been treated, he or she may no longer feel the need to be enrolled in Medicaid. The difficulties involved in obtaining and maintaining enrollment may no longer be perceived as worth the effort once care has been received and there are no imminent medical crises.

Eligibility Determination Has Grown Increasingly Complex

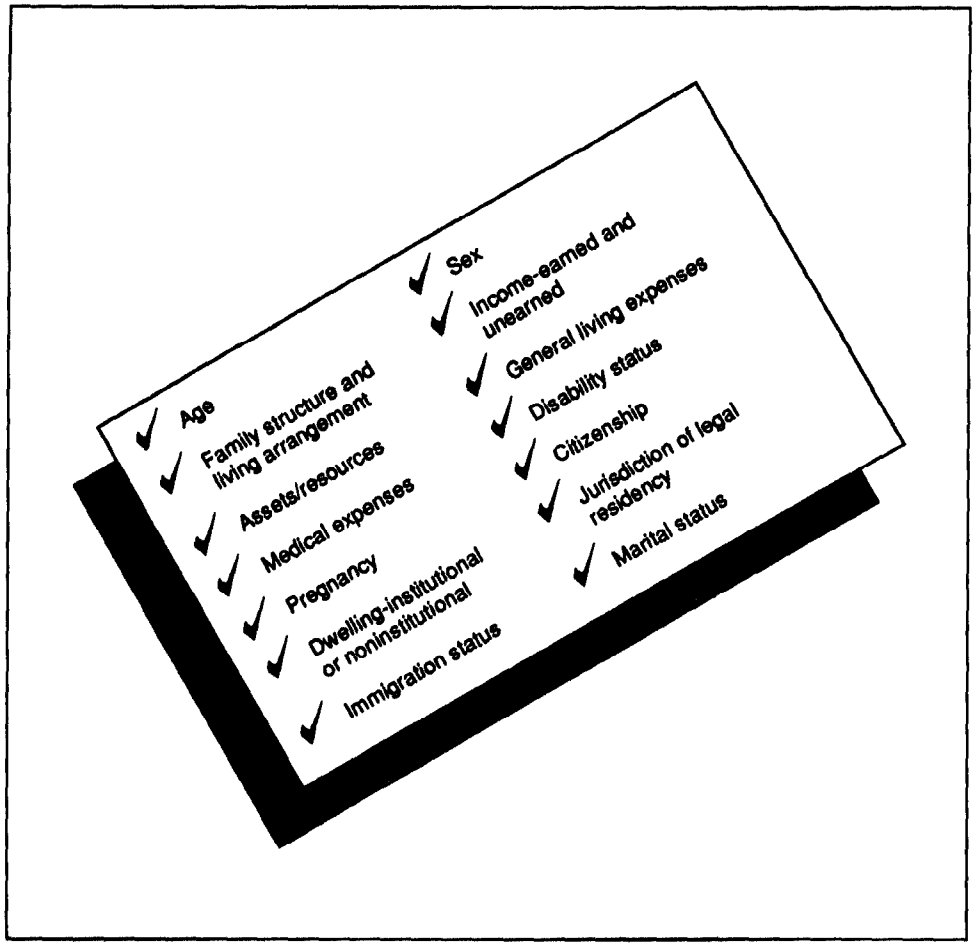
The application and enrollment process has grown more complex operationally for program staff partly as a result of numerous federal mandates and policy changes. According to District Medicaid officials, the complexity of eligibility rules and categories has seriously limited the usefulness of computer resources for program eligibility staff. Unlike eligibility determination for other means-tested welfare programs, determination of eligibility for non-AFDC Medicaid in the District is largely a manual process.

Eligibility for Medicaid benefits is tied to many factors beyond the individual's ability to pay for health care, such as those shown in figure IV.1. Medicaid eligibility workers must be familiar with all the possible combinations of these various factors that may entitle the applicant to benefits. In the District, there are 129 different "boxes" or program eligibility codes into which an applicant for Medicaid may fall: 79 eligibility codes for Medicaid; 12 conditional eligibility codes; [4] 27 ineligibility codes; and 11 eligibility codes for the District's Medical Charities program. [5]

[4]Conditional eligibility codes are for cases where an individual has met all requirements except, for example, a spend-down requirement.

[5]Medical Charities is a small program funded with District-only funds to help certain low-income individuals, who do not qualify for Medicaid benefits, pay for medical care. It was funded at $4.2 million in fiscal year 1991 but reduced to $1 million in fiscal year 1992.

Figure IV.1: Factors in Medicaid Eligibility



The federal government legislated numerous expansions of Medicaid eligibility and covered services between 1984 and 1990. [6] Many of these initiatives have created new eligibility categories or expanded existing categories by modifying eligibility criteria. From an operational standpoint, many of these same changes have added greater complexity for program eligibility staff.

Program officials cited this added complexity due to federally specified rules and criteria as a barrier to enrollment in the District. The complexity of eligibility requirements has made it increasingly difficult for the District

[6]We recently reported on 51 eligibility-related expansions to the Medicaid program since 1984. Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 13, 1991).

government to administer the program and keep up with the implementation of new requirements. For program managers, these numerous categories present significant challenges in terms of training eligibility workers, accounting for the various categories of enrollees, and program budgeting. As is the case in the states, the District government is constrained financially in its ability to respond to many of these new program rules.

Resources available to program staff to deal with this growing complexity are limited. Currently, eligibility determination for non-AFDC Medicaid is largely a manual process. Eligibility workers must be thoroughly familiar with all the categories. Policy and procedures manuals available to Medicaid eligibility workers are difficult to use and to update. One supervisor reported that eligibility workers rarely refer to these manuals for reference. They rely primarily on their own experience and guidance from supervisors when problems arise.

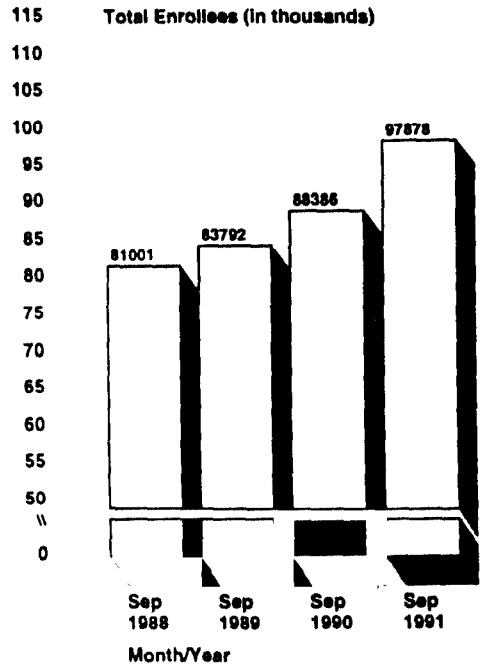
Insufficient Resources Directed to Medicaid Eligibility Determination in the District

The District government has devoted insufficient resources to performing eligibility determinations for the Medicaid program. While the District's welfare system is faced with steadily rising caseloads for its major public assistance programs, vacancies among eligibility workers have increased, eligibility workers receive little training, and staff turnover is significant. Applicants for Medicaid are often not able to secure sufficient assistance to complete the application process.

District Welfare System Pressured by Rising Caseloads

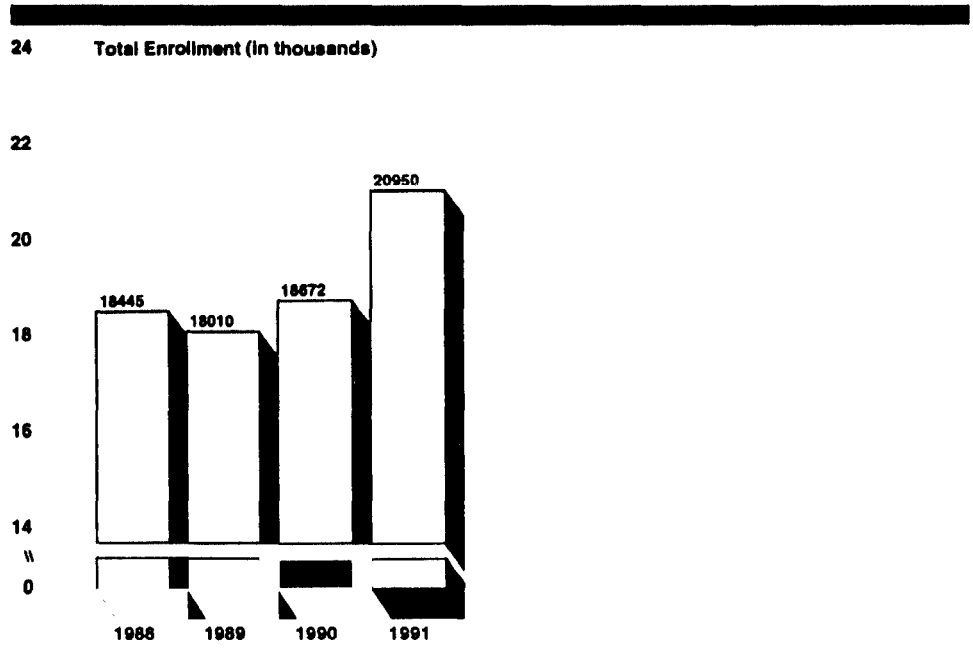
The welfare system in the District is under stress. Applications for—and enrollment in—the District's welfare programs have risen significantly over the past several years. This has led to workload increases for IMA, which manages eligibility for the District's three largest welfare programs—AFDC, Food Stamps, and Medicaid. From September 1988 to September 1991, total Medicaid enrollment increased by 21 percent, from 81,001 to 97,878, as shown in figure IV.2. For Medicaid enrollees also receiving other welfare benefits, such as AFDC or SSI, the increase during this period was 23 percent, from 69,672 to 85,495. For Medicaid enrollees not receiving cash assistance (those with fewer financial incentives to complete the application process), the increase was 9 percent, from 11,329 to 12,383. These figures represent only the total number of individuals actually enrolled in Medicaid. Data were not readily available to determine the overall volume of Medicaid applications received and processed over the period.

Figure IV.2: Medicaid Enrollment in the District of Columbia (1988-91)



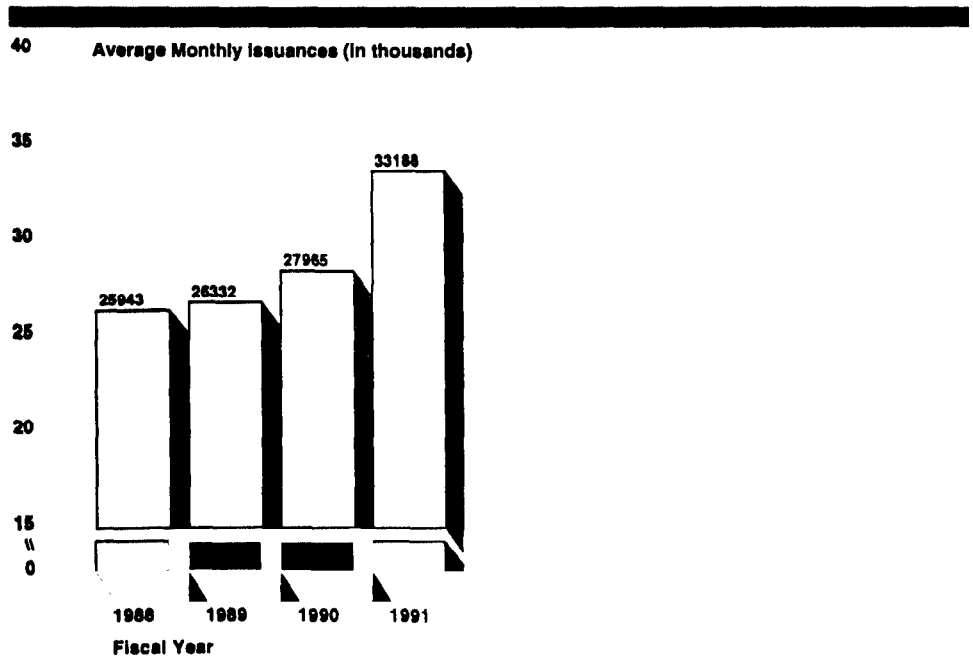
Caseloads for the AFDC and Food Stamp programs have increased over the past several years as well, as shown in figures IV.3 and IV.4. From 1988 to 1991, the average monthly AFDC caseload increased 13.6 percent, from 18,445 to 20,950. Over the same period, the average monthly number of households issued Food Stamps increased 28 percent, from 25,943 to 33,188.

Figure IV.3: AFDC Enrollment in the District of Columbia (Fiscal Years 1988-91)



Note: AFDC enrollment figures represent the average caseload for the year. On average, one case includes 2.65 persons. For example, the average caseload for 1991 was 20,950. This represents 55,448 individuals.

Figure IV.4: Food Stamp Issuances in the District of Columbia (1988-91)



Note: Figures are for the number of households issued food stamps in an average month.

Staffing Issues a Major Concern for Eligibility Determination

As caseloads and demand for services have been rising steadily, staffing in IMA has declined. Inadequate staffing levels were the primary operational reason cited by patient advocates and District government officials why many applicants do not receive sufficient assistance to successfully navigate the enrollment process. Since December 1987 total staffing in IMA program operations declined by 17 percent, as shown in figure IV.5. Senior IMA management estimated that vacancies among eligibility workers increased 64 percent from March 1989 to December 1991, as shown in figure IV.6. Another significant issue is staff turnover, which averaged 13 percent per year among eligibility staff from December 1987 to December 1991. In addition, Medicaid eligibility workers receive little training, and concern has been expressed that this may pose a significant barrier to enrollment.

Figure IV.5: Total IMA Program Operations Staffing (1987-91)

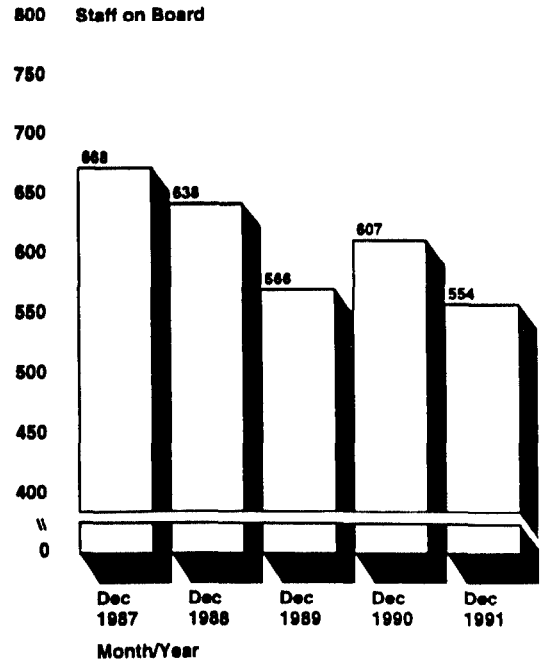
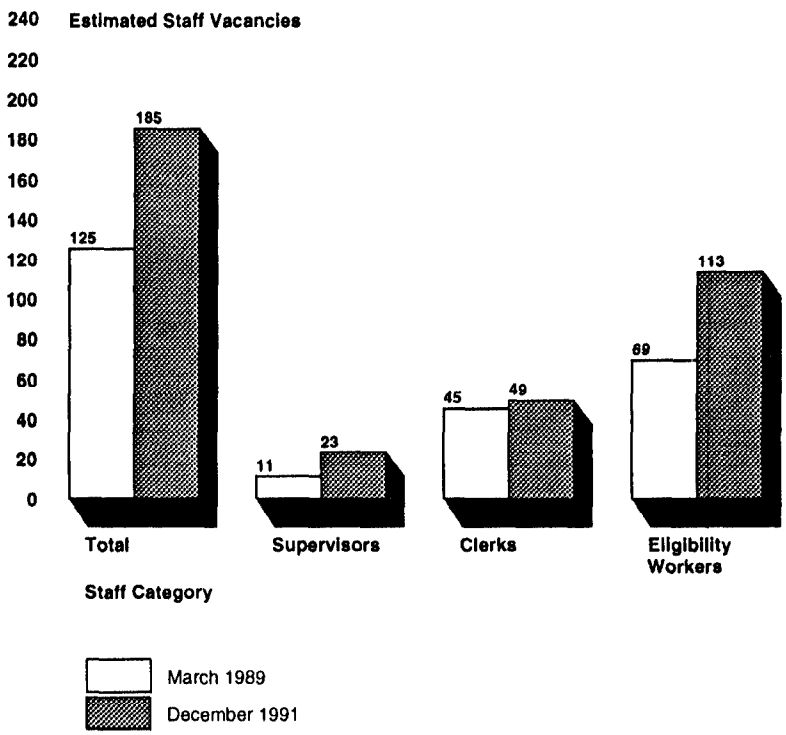


Figure IV.6: Increase in Estimated IMA Staff Vacancies (Mar. 1989-Dec. 1991)



Notes:

1. Vacancies are estimates by senior IMA management for staff involved in eligibility determinations for Medicaid and other welfare programs.
2. Data are taken from monthly IMA staffing reports. Data for March 1989 and December 1991 were used because not all months' reports were available.

The District's Medicaid director states that understaffing of eligibility workers is a significant problem. Staffing is at its lowest level in several years, while caseloads are at their highest level. There is a shortage of bilingual eligibility workers to facilitate enrollment for the growing Hispanic and multinational population of the District. Hospital vendor firm representatives state that the District government does not have enough staff to deal with the volume of applications for assistance that it receives. The Medicaid director stated that IMA needs to be authorized to hire additional staff to facilitate the processing of applications. Due to overall

District government budget difficulties, however, IMA's authority to fill vacant positions has been limited.

Most training of Medicaid eligibility workers occurs at the level of the individual worker and supervisor. One supervisor reported that newly hired eligibility workers receive only 1 week of formal training on the basic rules of Medicaid eligibility; the remainder of training is provided on-the-job by a supervisor. It can take up to 6 months to properly train a Medicaid eligibility worker, during which time the worker must be paired with a supervisor.

Medicaid eligibility workers give applicants a list of documentation needed and process completed applications. They do not help gather documentation materials. One eligibility supervisor stated that applicants often do not understand how or where to obtain the needed forms of documentation or verification. They need to be told and shown how to obtain many of the needed items. This supervisor also stated that as caseloads have increased dramatically, eligibility workers have much less time to devote to each case than they used to; there is not enough time to provide all the help that applicants need.

While the District does not know what portion of the potentially eligible population it is reaching and enrolling in the program, the Medicaid director stated that greater outreach and public education efforts are needed to reduce nonenrollment. One reason people may not seek Medicaid coverage is that they are unaware of their potential eligibility. As the link between cash welfare eligibility and Medicaid eligibility has been broken by the Medicaid expansions of recent years, a lack of knowledge of possible eligibility contributes to nonenrollment, especially by the non-AFDC-eligible populations. Welfare advocates contend that outreach to nonenrolled populations is not a priority for the states in general, and that outreach to some eligible populations—especially the newly eligible pregnant women and children—in the District is poor. As with staffing levels, budget limitations have limited the program's ability to expand these activities.

District's Efforts to Increase Medicaid Enrollment Are Modest

Despite the implementation of a new automated eligibility system for Medicaid and other welfare programs, the District government's efforts to improve eligibility system performance and increase Medicaid enrollment have been modest. While representatives of most hospitals we surveyed expressed their belief that on-site placement of Medicaid eligibility

workers (outstationing) would significantly help eligible patients become enrolled, such outstationing is limited to only one hospital in the District. Although the District complies with recent federal legislation mandating the use of outreach locations for receiving Medicaid applications, [7] expansion of eligibility worker outstationing is not currently planned.

A New Automated Eligibility System Has Potential to Improve Enrollment

IMA is implementing a new computer system for eligibility determination. Referred to as the Automated Client Eligibility Determination System, it is designed to integrate eligibility data for most programs run by IMA, most significantly Medicaid, AFDC, and Food Stamps. This system has the potential to simplify the application and reapplication process for eligibility workers and applicants.

Stated goals of the program include improving the timeliness and effectiveness of service delivery, providing an automated means to respond to workload increases and frequent changes in program policies, reducing the current manual processes performed by eligibility workers, and establishing the foundation for building a comprehensive client database. Pilot testing of this new system began in July 1992, with full District-wide implementation expected to be complete by August 1993.

For the eligibility workers, the new system will computerize much of the work currently done on paper. Eligibility workers will have a terminal on their desks. For example, the computer will eliminate the need for individual case worksheets. The automation of some manual tasks may free up some IMA staff to perform other tasks and may allow more time for detailed interviewing of applicants. A new complete set of documentation will not be required each time an applicant applies for a program benefit. However, the current 10-page application form is not being revised as part of this effort, and the initial documentation and verification requirements for Medicaid applicants will remain unchanged.

Assistance to Hospital Inpatients Is Minimal

Hospitals in the District have pointed to outreach as important not just to notify persons of their potential eligibility for Medicaid benefits, but to facilitate bringing them into the system. The District government has established a central Medicaid intake unit specifically to serve as a focal point for hospitals and to receive Medicaid applications for hospital inpatients, but it is not available to serve all hospitals. Outstationing of

[7]Omnibus Budget Reconciliation Act of 1990. Social Security Act, section 1902(a)(55). 42 U.S.C. 1396a(a)(55).

eligibility workers is provided through this unit to one hospital. Due to workload demands elsewhere in IMA, outstationed workers at a second hospital were recently reassigned. Further, overall staffing for the central Medicaid intake unit was recently reduced by nearly 30 percent—from seven eligibility workers to five, which includes two outstationed workers. Caseloads for the remaining workers have increased sharply. During a 9-month period of 1991, seven eligibility workers processed an average of 368 applications per month for inpatients of District hospitals.

Most applications received by this unit are denied Medicaid eligibility, not for failure to meet the eligibility criteria, but for applicant failure to comply with procedural requirements. An analysis of caseload data for the hospital unit workers for the 9-month period from March through November 1991 indicates that of 3,311 applications received from hospitals and vendor firms, only 1,037 (or 31 percent) were approved for either Medicaid or Medical Charities. The other 69 percent of applications were denied. Of these denials, 86 percent were for failure to comply with procedural requirements.

About two-thirds of all applications received by the hospital unit are for patients at D.C. General, the District's public hospital. For applicants from D.C. General, procedural denials account for more than 90 percent of all denials. Failure to secure Medicaid enrollment for eligible D.C. General patients means that the District government does not receive the 50-percent federal match under Medicaid and must assume the full cost of providing care to these patients if no other source of payment is available.

Expansion of Eligibility Worker Outstationing Not Planned

Outstationing of District government eligibility workers at hospitals in the District is very limited. Before December 1991, eligibility workers were stationed at two hospitals, Howard University and D.C. General. Currently, only Howard has eligibility workers on-site. The two workers at D.C. General were reassigned in December of 1991 due to pressing staff demands elsewhere in IMA.

Most hospitals in our review expressed their belief that outstationing of eligibility workers would greatly assist their efforts to secure enrollment for patients and reduce their uncompensated care. This view is supported by recent studies of state experiences, which report that outstationing eases the enrollment process for many eligible individuals, can increase the number and percentage of eligible persons who actually get enrolled,

and can help ease providers' level of uncompensated care. [8] Hospital officials contend that the application process should begin while the patient is still in the hospital; after discharge, patients are much less likely to follow up with the application requirements and become enrolled. Outstationed eligibility workers can serve as the hospitals' identified liaison with the District eligibility office, and the personal contact provided to applicants and hospital staff can help facilitate and expedite the Medicaid application process. Only two hospitals said that their volume of Medicaid applicants would be too low to justify placement of an eligibility worker.

A 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. [9] Final regulations for implementing these outreach provisions of the act have not been issued. However, 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 a person qualified to take Medicaid applications and assist individuals with the application process. The guidance states that the outstationed worker may be a government employee, provider employee, contractor, or volunteer. According to HCFA officials, the District complies with HCFA's most recent guidelines on outstationing at hospitals by maintaining a process for individuals to initiate the application at the hospital. Hospital employees and vendor firm representatives are available to assist applicants. District government officials stated that they would be willing to outstation District government eligibility workers at additional hospitals, but they do not currently have enough staff to do so.

[8]"Outstationing Medicaid Eligibility Workers at Community and Migrant Health Centers," National Governors' Association, 1992. "Administration of the Medicaid Eligibility Process," D.F. Beck and R.J. Buchanan, New England Journal of Human Services, Vol. VIII, Issue 4.

[9]"Mandatory Use of Outreach Locations Other Than Welfare Offices," Omnibus Budget Reconciliation Act of 1990. Social Security Act, Section 1902(a)(55). 42 U.S.C. 1396a(a)(55).

District of Columbia Medicaid Application

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

APPLICATION FOR MEDICAL ASSISTANCE

Please Read Carefully and Answer Every Question

OFFICE USE ONLY
Date Received: _____
Local Office: _____ DCID Number: _____
☐ AFDC-Related ☐ Approved
☐ SSI-Related ☐ Denied
☐ Medical Charities ☐ Spend-Down
Worker: _____
Date of Disposition: _____

PART 1: THE APPLICANT The applicant is the person who fits one of the following descriptions. Choose the description that applies to you. (If you are a child living with your parents or guardian, that person must apply for you.)

A. I am a parent, relative, or legal guardian of one or more children who need Medical Assistance. (You must be at least 21 years old, and the children must be under 21 and living with you.) ☐ Yes ☐ No

If yes, what is your relationship to the children? (mother, uncle, stepfather, other) _____
_____. Do you want Medical Assistance for yourself, too? ☐ Yes ☐ No

B. I am pregnant, age 21 or older, with no children who live with me. ☐ Yes ☐ No

C. I am under age 21 and *not* living with my parents or legal guardian. ☐ Yes ☐ No

If yes, where do your parents or legal guardian live? _____
_____. Are you a student? ☐ Yes ☐ No. If yes, what is the name of your school? _____.

D. I am 65 years old or older. ☐ Yes ☐ No

E. I am disabled or blind, and under age 65. (Your medical condition must either be permanent, or have lasted or be expected to last at least one year.) ☐ Yes ☐ No

F. I am between the ages of 21 and 65 with no children of my own who are living with me. (You must either be able to work now or be able to work as soon as you recover from a temporary medical condition.) ☐ Yes ☐ No

Name of Applicant: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME) (MAIDEN NAME)

Current Street Address: _____
(NUMBER AND STREET) (APARTMENT NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

Mailing Address: _____
(IF SAME AS ABOVE, WRITE "SAME")

Do you plan to remain in the District of Columbia? ☐ Yes ☐ No. If no, explain: _____

Home Telephone Number: _____ Another Telephone Number: _____
(WHERE YOU CAN BE REACHED DURING THE DAY)

Sex: ☐ Male ☐ Female Social Security Number: _____
(IF BLANK, ☐ NONE, OR ☐ UNKNOWN)

Date of Birth: _____ Place of Birth: _____
(MONTH) (DAY) (YEAR) (CITY AND STATE OR COUNTRY)

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other: _____

Marital Status: ☐ Never Married ☐ Married and Living with Husband or Wife ☐ Separated
☐ Legally Separated ☐ Divorced ☐ Widowed

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HUSBAND OR WIFE OF APPLICANT Complete this part even if the husband or wife is deceased or absent from the home.

Name of Husband or Wife: _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME) (MAIDEN NAME)

If deceased, date of death: _____ If absent from the home, date absence began: _____

Current Street Address: _____
(If same as applicant's, write "same") (NUMBER AND STREET) (APARTMENT NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

Sex: ☐ Male ☐ Female Social Security Number: _____
(IF BLANK, ☐ NONE, OR ☐ UNKNOWN)

Date of Birth: _____ Place of Birth: _____
(MONTH) (DAY) (YEAR) (CITY AND STATE OR COUNTRY)

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other: _____

CHILDREN UNDER AGE 21 LIVING WITH APPLICANT List any unborn child as "unborn". If there are no children, go to Part 5.

Full Name (LAST-FIRST-MIDDLE)	Social Security Number	Date of Birth (or EDC)	Place of Birth	Sex	Race	Relationship to Applicant	Is Child in School?
1.							☐ Yes ☐ No
2.							☐ Yes ☐ No
3.							☐ Yes ☐ No
4.							☐ Yes ☐ No
5.							☐ Yes ☐ No
6.							☐ Yes ☐ No
7.							☐ Yes ☐ No
8.							☐ Yes ☐ No

UNBORN CHILD [illegible] Part 5.

A. Absent Parents Is the parent of any child or unborn child absent from the home? ☐ Yes ☐ No

If yes, complete the boxes below, one set for each absent parent. If no, go to B.

1.

Name of Absent Parent	Names of His or Her Children	Date Parent Left	Reason Parent Left
Absent Parent's Current Address (as much as you know)			

2.

Name of Absent Parent	Names of His or Her Children	Date Parent Left	Reason Parent Left
Absent Parent's Current Address (as much as you know)			

B. Deceased Parents Is the parent of any child or unborn child deceased? ☐ Yes ☐ No

If yes, complete the boxes below, one set for each deceased parent. If no, go to C.

1.

Name of Deceased Parent	Names of His or Her Children	Date of Death

2.

Name of Deceased Parent	Names of His or Her Children	Date of Death

C. Incapacitated Parents Is there a parent living in the home who is not able to support his or her children because of an illness, accident, serious medical condition, or disability? (The incapacitation must be expected to last at least 30 days.) [redacted]

If yes, complete the boxes below, one set for each incapacitated parent. If no, go to D.

	Name of Incapacitated Parent	Date the Medical Condition Started	Describe the Medical Condition
1.			
2.	Name of Incapacitated Parent	Date the Medical Condition Started	Describe the Medical Condition

D. Unemployed Parents Is there a parent living in the home who is unemployed, but who is able and willing to work full-time? ☐ Yes ☐ No

If yes, complete the boxes below, one set for each unemployed parent. If no, go to E.

Name of Unemployed Parent	Date Last Worked	Reason for Leaving Job	Has Parent Applied for or Received Unemployment Benefits in the Last 12 Months? ☐ Yes ☐ No

Names and Addresses of Employers for the Last Five Years (most recent first)	Dates (from and to)
a.	
b.	
c.	
d.	
e.	

Name of Unemployed Parent	Date Last Worked	Reason for Leaving Job	Has Parent Applied for or Received Unemployment Benefits in the Last 12 Months? ☐ Yes ☐ No

Names and Addresses of Employers for the Last Five Years (most recent first)	Dates (from and to)
a.	
b.	
c.	
d.	
e.	

E. Under-Employed Parents Is there a parent living in the home who is employed less than 100 hours per month, but who is able and willing to work full time? ☐ Yes ☐ No

If yes, complete the boxes below. If no, go to Part 5.

Name of Under-Employed Parent	Number of Hours Working Per Month _____	Reason Parent is Not Working More Hours

Names and Addresses of Employers for the Last Five Years (current job first)	Dates (from and to)
a.	
b.	
c.	
d	
e.	

[redacted]

A. Was anyone who is included in this application born in a country *other than* the United States? ☐ Yes ☐ No

If yes, who? _____ Which country? _____

What is the person's status with the Immigration and Naturalization Service?

_____

What document do you have to show this? _____

B. Is anyone who is included in this application pregnant? ☐ Yes ☐ No

If yes, who? _____

C. Is anyone who is included in this application blind or almost blind? ☐ Yes ☐ No

If yes, who? _____

D. Is anyone who is included in this application permanently and totally disabled? Disabled means that the person has a physical or mental impairment that has lasted or can be expected to last at least one year, or that can be expected to result in the person's death. ☐ Yes ☐ No

If yes, who? _____

Describe the disability in a few words: _____

_____

E. Is anyone who is included in this application now making plans to enter a nursing home or other long-term care facility? ☐ Yes ☐ No

If yes, who? _____ When? _____

F. Is anyone who is included in this application in the military? (Include any absent parents in your answer.) ☐ Yes ☐ No

If yes, who? _____ Date of Service: _____

What branch of the military? _____

G. Is anyone who is included in this application a veteran of the military or the widow, spouse, child, or "Gold Star Mother" of a veteran? (Include any absent parents in your answer.) ☐ Yes ☐ No

If yes, who? _____ Dates of Service: _____

What branch of the military? _____

H. Is anyone who is included in this application in prison or jail, or on parole or work-release? (Include any absent parents in your answer.) ☐ Yes ☐ No

If yes, who? _____ Date of Imprisonment: _____

What is the name of the correctional facility? _____

I. Is anyone who is included in this application now receiving financial assistance, Medical Assistance, or Supplemental Security Income? ☐ Yes ☐ No

If yes, who? _____ Which one is received? _____

What city or state is providing this assistance? _____

J. Has anyone who is included in this application ever applied for and received *or* applied for and been denied financial assistance, Medical Assistance, or Supplemental Security Income in the past? ☐ Yes ☐ No

If yes, who? _____ Which one was applied for? _____

A. Does anyone who is included in this application have any *unpaid* medical bills for medical services that were received during the three months before the month of application? ☐ Yes ☐ No

If yes, complete the boxes below. If no, go to Part 7.

Kind of Medical Expense	Patient's Name	Date of Service	Amount Paid	Amount Still Owed
1.				
2.				
3.				
4.				
5.				

B. If there are any *unpaid* medical bills from the last three months, you can request retroactive Medical Assistance for these months. Do you want this application to be processed for the last three months? ☐ Yes ☐ No

If yes, answer the following questions:

1. Did your address change at any time during the last three months? ☐ Yes ☐ No
2. Was there any change in who was living with you? ☐ Yes ☐ No
3. Was there any change in anyone's income or assets? ☐ Yes ☐ No
4. If you answered yes to any of these questions, describe the changes.

_____

_____

PART 7: HEALTH INSURANCE

A. Does anyone who is included in this application have Medicare coverage? (Medicare is the health insurance that is provided by the Social Security Administration for the aged and the disabled.) ☐ Yes ☐ No

If yes, look at the person's Medicare Health Insurance Card (the red, white, and blue card) and complete the boxes below.

Names of Insured Persons	Medicare Claim Number	Type of Coverage
1.		☐ Hospital Insurance (Part A) ☐ Medical Insurance (Part B)
2.		☐ Hospital Insurance (Part A) ☐ Medical Insurance (Part B)

B. Does anyone who is included in this application have any other kind of health insurance or another kind of coverage for medical expenses, such as Blue Cross/Blue Shield, CHAMPUS, Veterans, or Group Health? ☐ Yes ☐ No

If yes, complete the boxes below.

Names of Beneficiaries	Name of Insurance Company	Policy Number or Certificate Number	Premium Cost or Membership Fee	How Often Paid	Who Pays for it?
1.			$		
2.			$		
3			$		

Does anyone who is included in this application have life insurance? ☐ Yes ☐ No

If yes, complete the boxes below.

Names of Insured Persons	Name of Insurance Company	Type of Policy (term or whole life)	Policy Number	Beneficiary	Date Issued	Face Value Payable at Death
1.						$
2.						$
3.						$
4.						$
5.						$

PART 9: ASSETS AND OTHER RESOURCES

A. Does anyone who is included in this application have any of the items listed below? Answer yes or no for each item.

If yes, give the names of the owners and how much the item is worth.

Type of Asset	Names of Owners	Total Amount or Dollar Value
Cash (money that is *not* in the bank) ☐ Yes ☐ No		$
Savings Accounts ☐ Yes ☐ No (1) Name of bank _____ Account #_____ (2) Name of bank _____ Account #_____		$
Checking Accounts ☐ Yes ☐ No (1) Name of bank _____ Account #_____ (2) Name of bank _____ Account #_____		$
Credit Union Account ☐ Yes ☐ No Name of C.U. _____ Account #_____		$
Savings Certificates ☐ Yes ☐ No		$
U.S. Savings Bonds ☐ Yes ☐ No		$
Stocks or Bonds ☐ Yes ☐ No		$
Money Market Funds or Mutual Funds ☐ Yes ☐ No		$
Trust Funds ☐ Yes ☐ No		$
Retirement Funds ☐ Yes ☐ No		$
Personal Funds in a Nursing Home Account or other Long-Term Care Facility Account ☐ Yes ☐ No		$
Automobiles (cars, vans, trucks) ☐ Yes ☐ No (1) Make/model/year _____ (2) Make/model/year _____		$
Other Vehicles (campers, trailers, boats, motorcycles, mobile homes) ☐ Yes ☐ No (1) Make/model/year _____ (2) Make/model/year _____		$
Other Assets or Items of Value (name them) ☐ Yes ☐ No (1)_____ (2)_____		$

B. Does anyone who is included in this application own or partly own any real estate or property other than the home in which you live? ☐ Yes ☐ No

If yes, what is owned? _____ Where is it? _____

Who owns it or who is buying it? _____

C. Does anyone who is included in this application jointly own something with a person who is *not* included in this application? ☐ Yes ☐ No

If yes, what is jointly owned? _____ Who are the owners? _____

D. Does anyone who is included in this application have a safe-deposit box? ☐ Yes ☐ No

If yes, are there any items of value in the box that you have not named above? ☐ Yes ☐ No

If yes, describe the items. _____

E. Does anyone who is included in this application own a promissory note, mortgage, land contract, or other contract of value? ☐ Yes ☐ No

If yes, describe the item and state its value. _____

F. Has anyone who is included in this application set aside money or invested money in a burial plot, contract, plan, or arrangement (other than life insurance) to cover funeral and burial expenses? ☐ Yes ☐ No

If yes, describe the arrangement and the investment. _____

G. Has anyone who is included in this application had an accident or illness that has caused the person to have medical expenses that should be paid by an automobile insurance company, another kind of insurance company, Worker's Compensation, or another person or organization? ☐ Yes ☐ No

If yes, has a claim or legal action been started? ☐ Yes ☐ No If yes, what is the current status of the claim? _____

H. Has anyone who is included in this application given away, sold, traded, deeded, transferred, or put into a trust any money or other items of value during the last 24 months? This includes items such as cash, bank accounts, stocks, bonds, real estate, automobiles, shares of insurance, and personal property. ☐ Yes ☐ No

If yes, what were the items? _____

Who received the items? _____ When? _____

What did you receive in exchange? _____

[redacted]

A. Do you own or are you currently buying your own home? ☐ Yes ☐ No

If yes, whose names are on the deed? _____

How much is your mortgage payment? $ _____

B. Are you paying rent for the house or apartment where you live? ☐ Yes ☐ No

If yes, how much rent do you pay? $ _____

C. Are you renting space in someone else's house or apartment? ☐ Yes ☐ No

If yes, how much rent do you pay? $ _____

Who pays for your food? _____

D. Are you living for free in someone else's house or apartment? ☐ Yes ☐ No

If yes, describe the arrangement. _____

Who pays for your food? _____

E. Is someone renting space from you in your home or apartment? ☐ Yes ☐ No

If yes, who? _____

How much rent do they pay you? $ _____ How often? _____

Who pays for their food? _____

F. Is someone renting space from you in any other buildings or on any other land that you own? ☐ Yes ☐ No

If yes, who? _____

How much rent do they pay you? $ _____ How often? _____

Do you act as the landlord/landlady or does a rental agency handle the arrangement for you?

_____

PART 11: EARNED INCOME

A. Is anyone who is included in this application self-employed? ☐ Yes ☐ No

If yes, complete the boxes below, one set for each self-employed person or job.

	Name of Self-Employed Person	Gross Income for the Last Tax Year $	Net Income for the Last Tax Year $	Gross Income Since January of this Year $	Net Income Since January of this Year $
1.					
2.					

B. Is anyone who is included in this application working for someone else? ☐ Yes ☐ No

If yes, complete the boxes below, one set for each employed person or job.

	Name of Employed Person	Name of Employer	Address of Employer	Job Title or Kind of Work
1.				
2.				
3.				

	Number of Hours Working per Month	How Often Paid (weekly, every two weeks, twice a month)	Gross Pay (amount earned before deductions) $	Net Pay (amount of "take home" pay) $
1.				
2.				
3.				

C. Is anyone who is included in this application paying a babysitter or day care center to take care of children while the employed person is at work? ☐ Yes ☐ No

If yes, who pays for the child care? _____

Who provides the care? _____

What children receive the care? _____

How much does the care cost? $_____ per ☐ Week ☐ Month.

D. Is anyone who is included in this application paying an attendant, nurse, or adult day care center to take care of an incapacitated adult while the employed person is at work? ☐ Yes ☐ No

If yes, who pays for the care? _____

Who provides the care? _____

What adult receives the care? _____ Why? _____

How much does the care cost? $_____ per ☐ Week ☐ Month.

E. Is there a blind person included in this application who has earnings and who has special work-related expenses because of being blind? ☐ Yes ☐ No

If yes, describe the special expenses. _____

_____

PART 12: UNEARNED INCOME

A Does anyone who is included in this application receive any of the kinds of income listed below? Answer yes or no for each item. If yes, give the name of the person who receives it and the amount of the check or payment

Type of Income		Who Receives It?	Amount of Check or Payment	How Often?
Social Security Benefits	☐ Yes ☐ No		$	
Second Social Security Check	☐ Yes ☐ No		$	
Railroad Retirement Benefits	☐ Yes ☐ No		$	
Black Lung Benefits	☐ Yes ☐ No		$	
Civil Service Annuity	☐ Yes ☐ No		$	
Veterans Administration Benefits	☐ Yes ☐ No		$	
Military or G.I. Dependency Allotments	☐ Yes ☐ No		$	
Unemployment Insurance Compensation	☐ Yes ☐ No		$	
Worker's Compensation	☐ Yes ☐ No		$	
Union Benefits	☐ Yes ☐ No		$	
Sick or Disability Benefits	☐ Yes ☐ No		$	
Training Allowances or Incentive Payments	☐ Yes ☐ No		$	
Money from Another Government Agency Name of Agency: _____	☐ Yes ☐ No		$	
Money from a Church or Other Organization Name of Organization: _____	☐ Yes ☐ No		$	
Money from a Relative or Friend From whom? _____	☐ Yes ☐ No		$	
Child Support or Alimony Payments From whom? _____	☐ Yes ☐ No		$	
Student Loan, Grant, Scholarship, Fellowship From whom? _____	☐ Yes ☐ No		$	
Life Insurance Proceeds or Annuity	☐ Yes ☐ No		$	
Dividends or Royalties from an Investment	☐ Yes ☐ No		$	
Interest from a Bank Account	☐ Yes ☐ No		$	
Trust Income	☐ Yes ☐ No		$	
Lump Sum or One-Time-Only Payment Describe: _____	☐ Yes ☐ No		$	
Other Unearned Income Describe: _____	☐ Yes ☐ No		$	

B Has anyone who is included in this application applied for but not yet started to receive any of the benefits listed above, *or* has anyone applied for and been denied any of the benefits listed above? ☐ Yes ☐ No

If yes, complete the boxes below

Kind of Benefit or Payment	Date of Application	Name of Person Who Applied	What is the Current Status of the Application (If Denied, Explain Why)
1.			
2			

C Are your total living expenses (not including your medical expenses) more than your total earned and unearned income? ☐ Yes ☐ No

If yes, explain how you have been managing, and how you plan to manage from now on.

_____

D Is there a blind or disabled person included in this application who has earned or unearned income and who is setting aside or using some of the income to become better able to take care of himself or herself? Examples of such a plan are saving money to buy special equipment or spending money on special training ☐ Yes ☐ No

If yes, describe the self-support plan _____

PART 13: UNDERSTANDINGS, AGREEMENTS, AND SIGNATURES

A.	I understand that I will be asked to provide proof of the information that I have given in this application. If the Department has reason to get a verification for me, the Department will obtain my signed permission first. If I refuse to provide the proof or if I refuse to give my permission, I understand that my application for Medical Assistance may be denied.	☐ Yes ☐ No
B.	I understand that the Department of Human Services will verify some of the information that I have given by using the computer matching system. My permission is not required for this. During this process, the Department will take care to protect my rights to confidentiality.	☐ Yes ☐ No
C.	I understand that I must report any changes in my situation that might affect my eligibility and I agree to report such changes no later than 10 days after the changes occur.	☐ Yes ☐ No
D.	I understand that my case may be chosen for a Quality Control review. This is a detailed review of all of the information in the case record and may include some personal interviews. If my case is chosen, I agree to cooperate fully with the state or federal Quality Control representatives. If I do not cooperate, my Medical Assistance may be terminated.	☐ Yes ☐ No
E.	I understand that if I believe I have been discriminated against because of my race, color, national origin, mental or physical handicap, or any other reason, I may file a complaint within 180 days to the D.C. Department of Human Services.	☐ Yes ☐ No
F.	I understand that if I am dissatisfied with any action or lack of action by the Department I may ask for a fair hearing.	☐ Yes ☐ No
G.	I understand that in the event of my death the Department will make a claim against my estate for the amount of Medical Assistance paid on my behalf after my 65th birthday. The Department will not make a claim if I die leaving a surviving husband or wife or a child who is under age 21 or who is blind or permanently and totally disabled.	☐ Yes ☐ No
H.	I understand that if I am eligible for Medical Assistance I am required to use all other available resources such as my health insurance, Medicare, Blue Cross/Blue Shield, veterans' insurance, and veterans' medical facilities before I use my Medical Assistance coverage.	☐ Yes ☐ No
I.	I understand that by signing this application I am assigning to the Department the right to collect payments from any health insurance company, other kind of insurance company, or any other person or organization that is responsible for my medical expenses. If I receive a payment directly from an insurance company or from someone else for a medical bill that has been paid by the Department, I agree to repay the Department from the money I receive.	☐ Yes ☐ No
J.	I understand that by signing this application I am accepting responsibility for this application, and that I am liable to criminal penalties if I have made any false or misleading statements, if I have willfully withheld information, or if I fail to report changes promptly. I understand that the maximum penalty for welfare fraud is a fine of $1,000 and a jail sentence of three years.	☐ Yes ☐ No
K.	I certify under penalty of perjury that the information I have given is true, complete, and correct to the best of my knowledge and belief.	☐ Yes ☐ No

Signature of Applicant _____ Date: _____
(LEGAL SIGNATURE OR "X" MARK)

Signature of Witness to an "X" Mark _____ Date: _____
(A witness is required only if the applicant makes an "X" mark instead of signing his or her name.)

Signature of Authorized Representative _____ Date: _____
(The applicant's authorized representative must sign if the applicant cannot sign or mark because of a physical or mental disability. By signing this form, the authorized representative accepts legal responsibility for the truth and completeness of the statements made on this application form.)

Name and Address of the Helping Person, Witness, or Authorized Representative (if any):

_____

_____

Title or Relationship to Applicant: _____ Daytime Telephone: _____

Documentation Standards and Requirements for Medicaid Eligibility in the District of Columbia

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

VERIFICATIONS FOR MEDICAL ASSISTANCE ELIGIBILITY

This is a general listing of the kinds of documents you may be asked to provide so that your caseworker may determine your eligibility for Medical Assistance. Some of these verifications are **always** required, and some are only **sometimes** required.

When you submit your application or recertification form, you should include as many of these as you can without spending a lot of time gathering them together. You will have more time to locate the documents after you have turned in the form. When we receive your form, a caseworker will give you **a list of exactly what is needed** in your particular case. If you have trouble getting one of the verifications that we ask for, you may ask the caseworker to help you. The caseworker may suggest another way that you can verify the information.

If you are reapplying, or if you are already a recipient and we are recertifying your eligibility at this time, you do not have to submit some of the legal documents that you gave us before, such as birth certificates and life insurance policies.

It is never a good idea to send your original documents through the mail. You may have photocopies made and mail us the copies, or you may bring us the original documents and we will photocopy them for your case record.

Age:	Birth Certificates for all members of the assistance unit.
Address:	Driver's license, rental agreement or other evidence that you live in the District of Columbia.
Citizenship:	Alien registration documents or naturalization papers for all persons born outside the United States.
Health Insurance:	Document or wallet ID card showing the name of the health insurance company, the claim numbers, and the names of the family members who are covered. For a nursing home patient, a receipt or cancelled check showing the premium amount and the period of coverage.
Pregnancy:	Doctor's statement for a pregnant woman who does not have other children living with her. The statement must include the estimated due date.
Disability:	Doctor's statement for a disabled applicant or for the incapacitated parent of a child under age 21. Your caseworker will give you a form for the doctor to complete.
Death:	Death certificate for a deceased applicant or for the deceased parent of a child under age 21.
Absence:	Evidence of separation when one of the parents of a child under age 21 is absent from the home on an on-going basis.
Unemployment:	Evidence of a work history and an application for Unemployment Compensation for the unemployed parent of a child under age 21.

(Continued)

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Employment:	Salary statements, paycheck stubs, pay envelopes, or a written statement from the employer showing the salary for the last four pay periods.
Self-Employment:	Last year's tax return, ledger books, accounting records, or bank statements showing the gross income, and records or receipts showing business expenses.
Pensions/Benefits:	Award letter, retirement fund document, benefits statement, or a written statement from the agency or organization making the payment. This includes Social Security, Veterans Administration benefits, Military Allotments, Railroad Retirement, Black Lung, Worker's Compensation, Unemployment Insurance benefits, and other pensions and benefits.
Contributions:	Court payment record, copy of the payment check, or a written statement from the person who is paying the child support or alimony or making the voluntary contributions.
Rental Income:	Leases, tax records, rental agency documents, or a written statement from each tenant or roomer/boarder; also bills and receipts for necessary expenses.
Investment Income:	Copies of payments or dividend checks, bank documents, or a written statement from the broker or investment firm.
Bank Accounts:	A current statement from the bank or financial institution. Bank accounts include savings, checking, trusts, certificates of deposit, credit union, and nursing home accounts.
Stocks and Bonds:	A written statement from the bank or stock broker, or a copy of the issuing corporation's document and a newspaper clipping showing the current value.
Life Insurance:	A copy of the title page and the table of cash values from each policy, or a written statement from the issuing company.
Real Estate:	Tax assessment, or a written statement of appraisal value from a local realtor; also a bank document showing how much you owe on a loan or mortgage. (We do not need to know about the value of the home in which you live.)
Adult or Child Care:	A receipt or written statement from the person or organization you are paying to care for your children or an incapacitated adult while you are at work.
Assistance From Another State:	If you lived in another state within the last three months and received Medical Assistance there, we need a notice of termination from the other state before we can give you assistance in the District of Columbia.

84-0P799

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