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Simplifying Enrollment in Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities

by

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The AARP Public Policy Institute, formed in 1985, is part of the Policy and Strategy Group at AARP. One of the missions of the Institute is to foster research and analysis on public policy issues of importance to mid-life and older Americans. This publication represents part of that effort.

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FOREWORD

The Medicaid program provides certain low-income Medicare beneficiaries with access to many services that Medicare does not cover. In addition, the Medicare Savings Programs (MSP), also known as Medicare Buy-In Programs, provide important help with Medicare's premium and cost-sharing obligations for low-income Medicare beneficiaries who are not eligible for full Medicaid benefits. Furthermore, Medicaid beneficiaries in either Medicaid or MSP receive the additional protection of being automatically deemed eligible for the low-income subsidy available under Medicare's new prescription drug coverage effective January 2006; these individuals also can be automatically enrolled in a Part D plan. Unfortunately, despite the value of Medicaid and Medicare Savings Programs for these Medicare beneficiaries, significant numbers of persons who are potentially eligible for either full Medicaid benefits or one of the Medicare Savings Programs are not enrolled.

Although low participation in these programs has been attributed to several factors, eligibility policy and enrollment practices play major roles. Efforts to simplify these policies have the potential to increase enrollment. Perhaps nowhere was this better demonstrated than with the success of state efforts to enroll children in the newly created State Children's Health Insurance Program (SCHIP) in the late 1990s and early 2000s. In recognition of the fact that the eligibility and enrollment policies and practices that affect beneficiary access to Medicaid and MSP are ultimately determined by states and in light of the dearth of comparable state-specific information about such policies and practices, the AARP Public Policy Institute initiated two research projects to fill the information void. The first, titled "Medicaid Eligibility Policy for the Aged, Blind and Disabled" and released in November 2003, reported on state eligibility policies as of 2001. The second project resulted in the current report, which focuses on the enrollment process and the extent to which states are engaged in simplification activities that make it easier for the elderly and disabled persons to enroll in Medicaid and MSP.

This issue paper, by Laura L. Summer and Emily S. Ihara of the Georgetown University Health Policy Institute, makes several contributions to policymakers' and program administrators' understanding of these programs. First, by identifying the minimum federal requirements for various enrollment practices under Medicaid and MSP, the paper reveals the opportunities for simplifying the process. Clearly stating these requirements is a critical step in dispelling myths about which practices states *must* engage in and which practices are subject to state discretion. Second, the paper reports on the results of a national survey of states on a broad range of Medicaid and MSP enrollment practices as of Fall 2002. In addition to providing state-level information about important aspects of these programs, the survey results serve as a baseline for assessing subsequent changes in policy and practice. Finally, it is our hope that the paper will be useful to state and federal policymakers who seek to maximize enrollment in the new Medicare prescription drug benefit and the special financial subsidies for which some Medicare beneficiaries with low incomes are entitled.

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Background

The Medicare program provides health insurance coverage for approximately 42 million people age 65 and older and younger individuals with disabilities. However, many beneficiaries incur substantial out-of-pocket costs for health care even though they have Medicare coverage. In some instances, they may forgo needed care that they cannot afford. Medicare cost-sharing requirements for premiums, deductibles, and coinsurance represent a significant portion of income for many beneficiaries.

Medicaid pays for prescription drugs and other services not covered by the Medicare program, and it is the primary public program paying for long-term care services. In addition, the Medicaid program provides protection from some or all of Medicare's cost-sharing for certain low-income individuals. Medicaid provides partial financial assistance with Medicare premiums, deductibles, or coinsurance—through the Medicare Savings Programs (i.e., Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, and Qualifying Individuals)—to certain low-income Medicare beneficiaries who are not entitled to the full Medicaid benefit package.

Even though Medicaid and the Medicare Savings Programs can be of great value to low-income beneficiaries, a significant number of those who are eligible do not participate in the programs. Two types of activities are frequently recommended to promote increased enrollment in public programs, including Medicaid and the Medicare Savings Programs. One is to reach out and inform people about the availability of benefits (outreach); the other is to simplify the enrollment process. Both types of activity are important, and ideally they should occur together. The focus of this report is on simplification of the enrollment process for the Medicaid program and Medicare Savings Programs for elderly persons and individuals with disabilities.

Purpose

This report examines practices related to several aspects of the enrollment processes for Medicaid and Medicare Savings Programs. It explains how each practice may affect program participation by persons who are elderly or disabled, and discusses the federal requirements related to each practice. It also presents the results of a national survey undertaken in fall 2002 to examine practices and innovations in states. The purposes of the report are to describe enrollment procedures, to discuss the impact that they may have had on enrollment, and to highlight opportunities for additional change. The information presented in this report should be useful to state and federal policymakers and program administrators as they consider how to simplify enrollment and renewal processes for Medicaid and the Medicare Savings Programs, and how to implement and administer the Medicare Part D low-income subsidy enrollment process.

Methods

In fall 2002, the Center on an Aging Society surveyed state Medicaid directors to learn whether they had implemented one or more enrollment simplification practices for the elderly and

individuals with disabilities seeking to participate in the Medicaid program or in Medicare Savings Programs. Aspects of the enrollment process that could be simplified include the following:

1. Application forms;
2. Documentation requirements;
3. Application submission and review processes;
4. Applicant identification and assistance; and
5. Recertification procedures.

Findings

Survey findings presented throughout this report refer specifically to state practices related to the elderly and persons with disabilities. As of fall 2002, every state and the District of Columbia had adopted at least one type of simplification practice for these populations. Of the 43 states that indicated a date when enrollment simplification activities began in their state, 32 reported that these efforts began in 1998 or later.

Modifying the application forms was the most common change that states had made to simplify the enrollment process.

The application form often provides the initial impression of the Medicaid program, and therefore is a critical part of the enrollment process. It can appear welcoming and informative or alternately, daunting. At least one report of states' experiences indicates that applications for the Medicare Savings Programs can be simplified without undermining the integrity of the Medicaid program (Glaun, 2002).

- Almost 40 states used applications for Medicaid or the Medicare Savings Programs designed to accommodate people with limited literacy skills.
- Most states translated applications into Spanish. In eight states, applications for Medicaid and the Medicare Savings Programs were available in languages other than English or Spanish. In 17 states, both types of applications were available only in English.
- Application forms that were four pages or shorter were available for the Medicare Savings Programs in 34 states.
- In some instances, focus groups had been convened as part of the process to develop better application forms.

A number of states had eliminated requirements for verification documents.

Eliminating documentation requirements for income and assets has the potential to reduce the administrative burden and costs associated with making Medicaid eligibility determinations. Time and money could be saved because eligibility workers would not have to review documents, contact applicants regarding missing documents, and close and reopen cases when documents were not provided during a certain time period.

- Income verification documents for Medicare Savings Programs were not required in 12 states.
- Documents to verify assets for Medicare Savings Programs were not required in 17 states.
- Income verification documents for the full Medicaid program were not required in five states.
- Asset verification documents for the full Medicaid program were not required in seven states.

A majority of states had eliminated the face-to-face interview requirement during the initial application process.

Eliminating face-to-face interview requirements could decrease the amount of time eligibility workers need to spend on each application. Thus, administrative costs could be reduced and eligibility workers could be reassigned to help applicants in other ways, such as providing more individualized attention for those who need it or reaching out to populations that might be unfamiliar with the programs. States that recertify program participants more often than annually could reduce administrative costs by conducting less frequent interviews.

- A face-to-face interview for the full Medicaid program was not required in 32 states, and a face-to-face interview for the Medicare Savings Programs was not required in 41 states. Even more states reported eliminating the face-to-face interview requirement for recertification.
- At least 45 states accepted Medicaid applications by mail, and 33 reported accepting Medicaid applications by facsimile, giving applicants the options to apply without going to a Medicaid office.
- Four states reported accepting applications for the Medicare Savings Programs by mail, and 34 accepted them by facsimile, giving applicants the option to apply without going to a Medicaid office.
- About 30 states had developed screening tools to determine if prospective applicants were likely to be eligible for benefits. The same number of states outstationed eligibility workers to assist elderly applicants and applicants with disabilities with applying for Medicaid or Medicare Savings Programs.

About half the states used persons who were not employed by the Medicaid program to assist applicants.

Well-trained volunteers could respond effectively to applicants' requests for assistance and could perform quality control functions by checking applications for errors or missing documents and helping applicants secure missing documents before applications were submitted for processing.

- In 22 states, volunteers and professionals who did not work for the Medicaid program were given some authority to assist people with applications for the full Medicaid program; 28 states did so for Medicare Savings Programs. Volunteers also provided information and referrals, helped obtain required documents, checked to be sure applications were complete, and conducted interviews.
- No state that reported using volunteers and professionals allowed them to make eligibility determinations.

Some states had made major changes in order to simplify the recertification process.

Recertification, redetermination, renewal, re-enrollment, and eligibility review are all terms that refer to the process of confirming that enrollees remain eligible for benefits. Some states require program participants to periodically reapply for benefits. Others require applicants to verify that their circumstances have not changed and, therefore, that they continue to meet program eligibility requirements. The more closely recertification resembles an automatic enrollment process, the more effective it is likely to be in re-enrolling individuals (Remler and Glied, 2003).

- Recertification forms containing the requisite information, which applicants could confirm by signature, were used for full Medicaid and the Medicare Savings Programs in 10 states.
- Passive recertification (i.e., program participants were notified that their benefits would continue unless they informed officials that their circumstances had changed) was used for full Medicaid in five states and for Medicare Savings Programs in four states.

Conclusion

In many states, the enrollment process for the elderly and individuals with disabilities in Medicaid and the Medicare Savings Programs was simpler in fall 2002 than just a few years earlier. Despite such progress, opportunities to simplify enrollment for this population still exist. Some policy changes, such as eliminating face-to-face interview requirements and providing translated written materials, had been adopted by many states, but not all. Other changes had not been widely adopted. For example, only a small number of states had eliminated documentation requirements or significantly simplified the recertification process. Efforts in states show that change is feasible and demonstrate how elements of the enrollment process can be designed to conform to, but not exceed, federal requirements. Enrollment simplification has advantages for applicants but may also be advantageous for states when administrative costs are reduced.

As states face the challenge of assisting with enrollment for the new Medicare Part D low-income subsidy, and as they consider the substantial overlap in the populations eligible for Medicaid benefits and the low-income subsidy, simplifying the enrollment process for Medicaid and the Medicare Savings Programs may become more attractive.

I. INTRODUCTION

Background

The Medicare program provides health insurance coverage for approximately 42 million people age 65 and older and younger individuals with disabilities. Even with Medicare coverage, however, substantial numbers of Medicare beneficiaries have difficulty paying for the health care they need. Medicare cost-sharing requirements for premiums, deductibles, and coinsurance can represent a significant portion of income. On average, Medicare beneficiaries age 65 or older spend 22 percent of their income on out-of pocket costs associated with Medicare. Vulnerable groups, such as the poor, minorities, and persons with chronic illnesses, spend an even larger proportion of income on out-of-pocket costs (Maxwell, Moon, and Segal, 2001).

Some low-income Medicare beneficiaries are protected from Medicare's cost-sharing because they are poor enough to qualify, in whole or in part, for assistance from the Medicaid program. Table 1 describes the Medicaid eligibility pathways for the elderly and individuals with disabilities as of 2002. Individuals who are eligible for full Medicaid benefits have coverage for many services not covered by the Medicare program, though the array of Medicaid benefits varies somewhat by state. In addition, Medicaid is the primary public program paying for long-term care services.

Table 1. Medicaid Eligibility Pathways for the Elderly and Individuals with Disabilities, 2002

A number of eligibility pathways are available to low-income individuals who are elderly or have disabilities and who wish to apply for Medicaid benefits. States are obligated to cover some categories of beneficiaries and have the option to cover others.

Individuals have several main eligibility pathways to receive full Medicaid benefits:

- They may qualify through eligibility pathways related to participation in the Supplemental Security Income (SSI) program. Although SSI program participants automatically qualify for Medicaid benefits in most states, certain 209(b) states use more restrictive eligibility standards. Some 32 states and the District of Columbia rely on the Social Security Administration to make Medicaid eligibility determinations on behalf of the state during the application process for SSI benefits, but in other states, individuals are required to file separate applications for SSI benefits and Medicaid benefits.
- States have the option of extending full Medicaid coverage to elderly individuals whose income is between the SSI threshold and the federal poverty line.
- States may use the optional Medically Needy program pathway, which allows individuals to subtract their medical expenses from their income over a period of time to qualify for benefits.
- States may allow individuals to qualify through pathways for long-term care coverage in a nursing facility or in the community.

Medicare Savings Programs, which provide assistance with the costs of Medicare premiums and cost-sharing, are comprised of three different programs and eligibility pathways: the Qualified Medicare Beneficiaries program (QMB), the Specified Low-Income Medicare Beneficiaries program (SLMB), and the Qualifying Individuals (QI) program.

SOURCE: Georgetown University Health Policy Institute

Medicaid also provides partial protection—through the Medicare Savings Programs (MSP)—to low-income Medicare beneficiaries not entitled to the full Medicaid benefit package. The Medicare Savings Programs, sometimes called "Medicare Buy-in Programs," include the Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), and Qualifying Individuals (QI) programs. These programs provide premium protection and, in some cases, Medicare cost-sharing protection, for Medicare beneficiaries with low incomes and few resources. Benefits are provided to Medicare beneficiaries with countable income at or below 135 percent of the federal poverty level and countable assets up to $4,000 per individual or $6,000 per couple (Table 2). Individuals who are eligible for full Medicaid benefits generally also qualify for MSP.

Table 2. Financial Eligibility Criteria and Benefits for the QMB, SLMB, and QI Programs

Program	Countable Income Limits	Countable Asset Limits	Benefits
Qualified Medicare Beneficiaries (QMB)	At or below 100% of the federal poverty level*	$4,000 for an individual $6,000 for a couple	Medicaid pays all Medicare Part B premiums ($78.20 per month in 2005) and cost-sharing charges**
Specified Low-Income Medicare Beneficiaries (SLMB)	Between 100% and 120% of the federal poverty level	$4,000 for an individual $6,000 for a couple	Medicaid pays Medicare Part B premiums ($78.20 per month in 2005)
Qualifying Individuals (QI)***	Between 120% and 135% of the federal poverty level	$4,000 for an individual $6,000 for a couple	Medicaid pays Medicare Part B premiums ($78.20 per month in 2005)

SOURCE: Schneider et al., 2002. Revisions by the Center on an Aging Society add values for current rules and benefits.
*In 2005, the federal poverty level is $9,579 for individuals and $12,830 for couples. *Federal Register*, Vol. 70, No. 33, Feb. 18, 2005, pp. 8373-75.
**States are only required to pay cost-sharing up to the Medicaid payment rate if the Medicare rate for a given service is higher.
***The QMB and SLMB programs are entitlement programs, but qualifying individuals do not have an entitlement to assistance. Federal program funding is capped each year and has been extended until September 30, 2005.

Although Medicaid and the Medicare Savings Programs are of great value to low-income Medicare beneficiaries, a substantial number of those who are eligible do not participate in the programs. For example, estimates using Centers for Medicare and Medicaid Services (CMS) data indicate that 53 percent of people eligible for the QMB and SLMB programs were not participating in 1996 (Barents Group LLC, 1999b). Applications for full Medicaid coverage or for the Medicare Savings Programs are made through the state Medicaid office. Unlike the Medicare program, which is federally financed and operated, the Medicaid program is jointly financed and administered by states and the federal government. Thus, Medicaid program

eligibility rules and enrollment practices vary from state to state, and program participation rates also vary.

Several authors have identified a number of reasons for low participation rates among people who are eligible for Medicaid or the Medicare Savings Programs (Barents Group LLC, 1999a, 1999b; Glaun, 2002; Perry, Stark, and Valdez, 1998; Rosenbach and Lamphere, 1999). These reasons include the following:

- Limited awareness of the programs and program benefits;
- Confusion about eligibility criteria for the programs;
- Communication barriers related to language, culture, age, vision, and hearing;
- Wariness of government programs;
- Confusion and anxiety related to Medicaid estate recovery rules;
- Complex enrollment processes; and
- Complicated renewal processes.

The need to reach and enroll more eligible people in Medicaid and Medicare Savings Programs is well recognized. Since 1998, when CMS specified increased enrollment in Medicare Savings Programs as a goal under the Government Performance Review Act (GPRA), the agency has developed outreach materials for states and community-based organizations, and has sponsored initiatives to increase enrollment in Medicare Savings Programs. In 1999, CMS sponsored a "Reach Out" conference to encourage state officials and advocates across the country to promote efforts to increase enrollment in Medicare Savings Programs. In addition, AARP's Public Benefits Outreach Project has promoted enrollment in Medicare Savings Programs. Currently, the Robert Wood Johnson Foundation and the Commonwealth Fund are sponsoring State Solutions: An Initiative to Improve Enrollment in Medicare Savings Programs, which includes an emphasis on improving state eligibility and enrollment systems.

In the late 1990s and early 2000s, states placed more emphasis on efforts to increase enrollment rates for children in the Medicaid program and the State Children's Health Insurance Program (SCHIP). Although not every enrollment strategy geared toward families with children is appropriate for other populations, some of what has been learned from these efforts might be effective for increasing enrollment of the elderly and individuals with disabilities.

Generally, two types of activities are recommended to promote enrollment in public programs: (1) reaching out and informing people about the availability of benefits (outreach) and (2) simplifying the enrollment process. Both types of activities are important and ideally would occur together. The focus of this report is on simplifying enrollment processes for the Medicaid program and Medicare Savings Programs for the elderly and individuals with disabilities.

Simplification increases program enrollment. A study of states with enrollment gains in Medicare Savings Programs demonstrates that practices that simplify the enrollment process can have a positive impact on program participation (Glaun, 2002). Other studies have concluded that differences in application requirements and eligibility determination practices can affect beneficiaries' ability to obtain and keep coverage (U.S. General Accounting Office [GAO], 2001). A study of state practices related to Medicaid enrollment for children shows that states

that did the most to simplify enrollment had, on average, greater growth in enrollment than states that did less (Burke, 2003).

Purpose

This report provides an indication of the extent to which states had simplified enrollment and renewal processes for Medicaid and the Medicare Savings Programs as of fall 2002. It also describes an array of changes in policy and practice that states can make to ease enrollment and renewal for beneficiaries. Because there is substantial overlap in the populations eligible for Medicaid and the Medicare Savings Programs, and for the new Medicare Part D low-income subsidy, and because individuals eligible for Medicaid and the Medicare Savings Programs will be deemed eligible for the subsidy, this report can serve as a resource for state officials as they develop new procedures to enroll applicants into the Medicare Part D low-income subsidy program. The information should also be useful as officials consider how best to coordinate the enrollment and renewal processes for the two types of benefits.

Methods

In fall 2002, the Center on an Aging Society asked state Medicaid directors to complete a written survey about practices related to the enrollment process for elderly persons and individuals with disabilities seeking to participate in the Medicaid program or in Medicare Savings Programs (Appendix). In addition, a literature review and a review of federal program requirements related to eligibility and enrollment were conducted.

The survey examined the following enrollment practices:

1. Application forms;
2. Requirements for documentation;
3. Application submission and review;
4. Efforts to identify and assist applicants; and
5. Recertification procedures.

Responses were received from 49 states and the District of Columbia. New Mexico declined to participate in the survey. Respondents were contacted and given the opportunity to verify the data that are presented in this report. In some cases, states provided additional and/or illustrative information during follow-up contacts. State-specific information that is not reflected on the survey instrument is derived from these follow-up contacts.

II. APPLICATION FORMS

Approaches to Simplifying Application Forms

The application form often provides the initial impression of the Medicaid program and therefore is a critical part of the enrollment process. The form can appear welcoming and informative or can be daunting. At least one study has found that application forms for Medicare Savings Programs can be simplified without undermining the integrity of the Medicaid program (Glaun, 2002). Our survey addressed four issues related to application forms:

1. The length of application forms;
2. The use of joint program applications;
3. The availability of applications in languages other than English; and
4. The availability of applications to accommodate people with limited literacy skills.

Shortened Application Forms

Shortening the application form is one of the most frequently recommended strategies for simplifying the Medicaid enrollment process (Cohen Ross and Jacobson, 1998; Ellwood, 1999; Nemore, 1999; Perry, Stark, and Valdez, 1998; Rosenbach and Lamphere, 1999). Applicants may be discouraged or intimidated by forms that are lengthy, complicated, or confusing. For example, in focus groups of low-income seniors, participants said they felt intimidated by the length of the Medicaid application. Some also felt that certain questions on the application were repetitive, contributing to its length (Perry, Kannel, and Dulio, 2002).

Applications that are concise and ask only relevant questions are more likely to be effective. When evaluating applications, the number of pages is commonly used to help determine how user-friendly an application is, and generally provides an idea of how complicated it is (Cohen Ross and Jacobson, 1998). It is important to note, however, that length is only one of a number of factors to consider. For example, some state Medicaid agencies that use short application forms may still have cumbersome application processes because they require more follow-up information or more verification documents. Some states have longer application forms because they include information for the applicant, such as a list of documents to bring to the appointment, or because they use a large font to make the application easier to read.

States already have a good deal of experience using shortened forms to enroll children in the Medicaid program. As of December 2000, 39 states, including the District of Columbia, used applications of five pages or fewer for families applying for Medicaid benefits for children (CMS, 2001a).

Federal Requirements

Federal regulations require that Medicaid applications be in a written form approved by the state Medicaid agency and signed by the applicant under penalty of perjury (Written Application Rule, 1999). States may design their application form in any manner, as long as the form gathers the information required to make an eligibility determination. States are encouraged to design

applications that are simple, easy to administer, and promote the best interests of the applicant (Simplicity of Administration Rule, 1999).

Over the past several years, CMS has encouraged states to shorten Medicaid applications. In 1991, the agency developed a four-page model application for pregnant women and their children. A provision in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) directed the Department of Health and Human Services (DHHS) to develop a simplified model application form for states to use, at their option, for applicants for Medicare Savings Programs. A revised two-page model application is available on the CMS Web site (CMS, n.d.).

States are required to give all applicants written information about the Medicaid eligibility requirements and available services (Availability of Program Information Rule, 2001). Federal law requires that states affirmatively exhaust all possible avenues of Medicaid eligibility for each completed application (CMS, 2001a). Because of this requirement, some states have opted to use one application form for all types of Medicaid eligibility. However, states may also use separate forms for Medicare Savings Programs as long as they screen for eligibility for fuller Medicaid coverage and give applicants explanations of all the possible eligibility pathways. Federal law also requires states to allow individuals who are eligible under more than one category to choose the category of eligibility determination (Applicant's Choice of Category Rule, 2001).

Findings: Length of Application Forms

The survey found some striking differences in the length of applications for full Medicaid and Medicare Savings Programs (Table 3). In Rhode Island, for example, a 28-page application for full Medicaid coverage was reduced to 4 pages for Medicare Savings Programs; in West Virginia the 24-page application for full Medicaid was reduced to 2 pages for Medicare Savings Programs; and in Ohio a 34-page application for full Medicaid was reduced to 4 pages for Medicare Savings Programs. The following survey results highlight differences in state practice:

- About half the states reported that the same application form was used for all types of Medicaid coverage of elderly and disabled persons, including full coverage and coverage for Medicare Savings Programs.
- In states that used the same form for all types of Medicaid coverage, the applications ranged from 1 to 22 pages in length, but nine of these states had applications that were 4 pages or shorter.
- In states that used different applications for different types of Medicaid coverage, applications for full Medicaid coverage ranged from 1 to 34 pages, but most were 4 pages or shorter for Medicare Savings Programs.
- Regardless of whether one form or separate forms were used, in at least 34 states applications for Medicare Savings Programs were four pages or shorter.
- Different applications were used at different locations in some states. Maryland allowed the use of a three-page application form for the QMB and SLMB programs if the Area Agencies on Aging provided assistance to applicants. If beneficiaries applied for the programs at their local department of social services, a full 23-page application was required to ensure that beneficiaries were evaluated for all available benefits, including food stamps.

- New Hampshire had a similar arrangement with Housing and Urban Development (HUD) programs and the Health Insurance Counseling Education and Assistance Service (HICEAS) program. Applicants who went through any HUD program or used a HICEAS volunteer were allowed to use a two-page application form developed especially for the Medicare Savings Programs.

Joint Application Forms

Joint program applications allow people to apply for Medicaid and other programs, such as the food stamp program or cash assistance, at the same time. Joint applications can streamline the enrollment process and reduce administrative costs by allowing program eligibility workers to screen for multiple programs with the same application. A joint application system uses a single point of entry, such as a state agency, that is authorized to make the final eligibility determination for two or more programs. Alternatively, one program can pass the information on to another program with permission from the applicant. Joint program applications are especially helpful when applicants who may be eligible for other types of public programs are not aware of the availability of such assistance.

Federal Requirements

There are no federal requirements regarding the use of joint applications or Medicaid-only applications. When persons are allowed to use a single application form to apply for Medicaid and other programs that serve low-income individuals, the information required to determine Medicaid eligibility must be clearly specified in the joint application to ensure that the information requirements of other programs do not delay the processing of the Medicaid portion of the application (CMS, 2001a).

Federal regulations require that every Medicaid application receive a finding of eligibility or ineligibility unless the applicant withdraws the application or is deceased (Case Documentation Rule, 1999). Therefore, when using joint application forms, states may not deny eligibility to Medicaid based on ineligibility for another program and then advise the applicant to reapply for Medicaid (CMS, 2001a). For example, if an applicant uses a joint Medicaid/food stamp application but is determined ineligible for food stamps, the Medicaid portion of the application must still be acted upon.

Findings: Joint Application Forms

While some state officials noted that joint applications must be lengthier than single-program applications because they must conform to requirements imposed by a number of programs, other states reported that they use relatively short forms for multiple programs. The following are highlights of other findings related to the use of joint applications (Table 3):

- Medicaid applications for the elderly and people with disabilities could also be used for non-Medicaid programs in 32 states.
- Of the states reporting using joint applications, 29 included the food stamp program. Cash assistance, state supplemental payment programs, and energy and heat assistance were examples of other non-Medicaid programs included in some joint applications.

Table 3. Length of Full Medicaid and Medicare Savings Programs Application Forms for the Elderly and Individuals with Disabilities, 2002

	Is the Same Form Used for Full Medicaid and Medicare Savings Programs?	How Many Pages Is the Form?	If Different Forms Are Used, How Many Pages Is Each Form? *		Are Medicaid Applications Used for Other Non-Medicaid Programs As Well?
STATE	**YES**		**Full Medicaid**	**Medicare Savings Programs**	**YES**
Alabama			12	4	
Alaska	x	8			x
Arizona	x	4			
Arkansas			4	4	
California			4	3	
Colorado	x	22			x
Connecticut			14	4	x
Delaware	x	2			
District of Columbia			15	4	x
Florida			1	2**	x
Georgia			4	4	x
Hawaii	x	7			x
Idaho	x	3			x
Illinois			4	4	x
Indiana			1	1	x
Iowa	x	4			x
Kansas	x	6			x
Kentucky	x	***			x
Louisiana			6	2	
Maine	x	2			x
Maryland			23	3	x
Massachusetts	x	8			
Michigan	x	7			x
Minnesota	x	4		****	x
Mississippi	x	6			
Missouri			4	2	
Montana			16	4	x
Nebraska	x	11			x
Nevada	x	8			x
New Hampshire			6	2	x
New Jersey			8	2	x
New Mexico	--	--	--	--	--
New York			16	1	x
North Carolina	x	10			
North Dakota	x	16			x
Ohio			34	4	x
Oklahoma	x	10			x
Oregon			10	2	
Pennsylvania			16	4	x
Rhode Island			28	4	
South Carolina			4	2	
South Dakota			12	6	
Tennessee	x	1			x
Texas			7	3	
Utah	x	4			
Vermont			15	2	
Virginia	x	14			x
Washington			6	4	x
West Virginia			24	2	x
Wisconsin	x	7			
Wyoming	x	2			x
TOTAL	24				32

SOURCE: Georgetown University Health Policy Institute

***** Figures represent the number of pages applicants must complete. For example, a one-page double-sided form was counted as two pages.

****** The Medicare Savings Programs application in Florida was longer than the one-page request for assistance for full Medicaid because the Medicare Savings Programs application did not require a face-to-face interview and therefore asked for more information.

******* Kentucky did not have a paper application form. All applications were completed with eligibility workers and submitted by computer.

******** Minnesota pilot tested a two-page application form for the Medicare Savings Programs, and planned to use a two-page form in the future.

- Some states had longer applications because they were used for a number of programs, including medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF) and, therefore, asked more detailed questions for these programs. However, other states that asked about multiple programs had shortened application forms. Illinois, for example, reported having a four-page basic form to request medical assistance and other types of assistance. Tennessee reported using a two-page application form to request medical assistance and other types of assistance.
- Of the states that used joint applications, 10 had application forms that were four pages or shorter.

Translated Application Forms

One barrier to enrollment in Medicaid and Medicare Savings Programs for a substantial number of potentially eligible people is that they are not proficient enough in English to comprehend the complex Medicaid eligibility rules and complete an application (Ellwood, 1999). Of the more than 4 million people age 65 and older in the United States who speak a language other than English, 53 percent reported that they speak English less than "very well."[1]

In a study specific to the Medicaid program, 46 percent of 1,335 low-income parents surveyed in Spanish said they did not complete the Medicaid application because the forms and information were not translated. The same study found that about half the respondents said they did not bother to apply because they believed that the application materials would not be available in their language (Perry, Kannel, Burciaga Valdez, and Chang, 2000). These findings suggest that having applications available in languages other than English would encourage people to apply for benefits and make the application process easier for them.

The Office for Civil Rights (OCR) of DHHS is the federal agency responsible for enforcing civil rights laws, including those that require language access to government programs. In the course of its enforcement activities, OCR found that people with limited or no English proficiency were often unable to obtain the basic information they needed regarding benefits and services, such as Medicare, Medicaid, SCHIP, TANF, basic health care, and social services. Persons unable to communicate in English were often turned away, made to wait for a long time, forced to return to the office repeatedly until an interpreter was available, or forced to find their own interpreters (Office for Civil Rights, 2001).

Federal Requirements

All federal agencies are required to provide meaningful access to services for people with limited or no English proficiency (Executive Order No. 13166, 2000). The OCR requires organizations and programs receiving federal funds to provide appropriate language assistance to people with limited English skills who are seeking services (OCR, 2001). The enforcement authority for these requirements is derived from Title VI of the Civil Rights Act of 1964, which prohibits discrimination or exclusion from any program or activity receiving federal financial assistance based on race, color, or national origin (Civil Rights Federally Assisted Programs Act, 2002).

[1] Center on an Aging Society analysis of data from U.S. Bureau of the Census (2000).

Implementing regulations specify that agencies may not use criteria or methods that effectively subject individuals to discrimination because of race, color, or national origin (Nondiscrimination under Programs Receiving Federal Assistance through DHHS Rule, 2002). Extensive case law further clarifies that failure of federally funded programs to accommodate those who are unable to speak and understand the English language constitutes exclusion based on national origin (see, for example, *Yu Cong Eng et al. v. Trinidad, Collector of Internal Revenue, 1926; Lau v. Nichols, 1974; Garcia v. Gloor, 1980, 1981; Gutierrez v. Municipal Court of S.E. Judicial District, 1988; Sandoval v. Hagan, 1999, 2000*).

The OCR and the Department of Justice have provided guidelines for the implementation of policies regarding language access. The guidelines state that, in order to ensure meaningful access to health and social service benefits, language assistance must be provided at no cost to the applicant. The type of language assistance needed depends on four factors (OCR, 2001):

1. The size of the population with limited or no English proficiency served by the agency;
2. The frequency with which people with limited or no English skills come in contact with the program;
3. The nature of the program or service provided; and
4. The resources available to the agency or program.

Language services can be provided in two ways: (1) oral interpretation and (2) written translation. Agencies can contract with professional interpreters, employ bilingual staff, or use language banks to fulfill oral interpretation requirements. The use of informal interpreters, such as family or friends, is not an acceptable way of providing linguistic access (Department of Justice, 2002).[2]

In large urban areas where programs may regularly serve people who collectively speak dozens of different languages, not all materials need to be translated into every language. Table 4 provides guidelines on the types of materials that must be translated based on the size of the population (OCR, 2001). Under the Medicaid program, federal matching funds are available to states for oral and written translation activities and services (Westmoreland, 2000b).

[2] The Social Security Administration has a nationwide contract for telephone interpreter services in more than 150 languages and dialects. More information about this service can be found in Policy No. GN 00203.011 at http://policy.ssa.gov/poms.nsf.

Table 4. Guidelines for Translating Materials about Federal Programs, 2002

Group Composition:	Documents to Be Translated
10% of the eligible population to be served or 3,000 persons, whichever is less	All written materials. Large documents, such as enrollment handbooks, may not need to be translated in their entirety, but vital information contained in such documents must be translated.
5% of the eligible population to be served or 1,000 persons, whichever is less	Written vital documents, including applications, consent forms, letters regarding eligibility or participation criteria, and notices pertaining to reduction, denial, or termination of benefits that require a response from the beneficiary, and/or that advise of free language assistance. Translation of other documents can be provided orally.
Fewer than 100 persons	Written notice in the primary language of that group must be provided advising them of the right to receive competent oral interpretation of written materials, free of cost.

SOURCE: Department of Justice, 2002

Findings: Translated Application Forms

A significant number of states surveyed reported using translated Medicaid application forms. Most of these states provided a Spanish version of the form. Highlights from the survey include the following findings:

- Of the 33 states that had translated applications for full Medicaid coverage into languages other than English, all but 7 had translated the applications for the Medicare Savings Programs as well (Table 5).
- In states where applications were translated, they were always available in Spanish. Only eight states offered applications in languages other than English and Spanish (Table 6).
- Kansas, Mississippi, Oregon, and Vermont noted that, while they did not have their materials translated or had not translated them into all of the languages spoken in their state, interpretation or translation services were available as needed.
- In California, Florida, and New Hampshire, applications for full Medicaid were translated into more languages than applications for Medicare Savings Programs.
- Survey results clearly demonstrate that translation of applications for Medicare Savings Programs had ***not*** kept pace with translation of applications for full Medicaid.

Table 5. The Availability of Full Medicaid and Medicare Savings Programs Applications that Accommodate Other Languages and Limited Literacy Skills for the Elderly and Individuals with Disabilities, 2002

	Are Application Forms Printed in Languages Other Than English?		Are Applications Designed to Accommodate Limited Literacy?*	
	Full Medicaid	**Medicare Savings Programs**	**Full Medicaid**	**Medicare Savings Programs**
STATE	YES	YES	YES	YES
Alabama			x	x
Alaska			x	x
Arizona	x	x	x	x
Arkansas	x	x		
California	x	x	x	x
Colorado	x	x		
Connecticut	x	x	x	x
Delaware	x	x	x	x
District of Columbia	x		x	x
Florida	x	x		
Georgia	x		x	x
Hawaii				
Idaho	x	x	x	x
Illinois	x	x	x	x
Indiana	x	x	x	x
Iowa	x	x	x	x
Kansas				
Kentucky			x	x
Louisiana	x	x	x	x
Maine			x	x
Maryland	x		x	x
Massachusetts	x	x	x	x
Michigan	x	x	x	x
Minnesota	x	x	x	x
Mississippi				
Missouri				
Montana			x	x
Nebraska			x	x
Nevada	x	x	x	x
New Hampshire	x		x	x
New Jersey	x	x		x
New Mexico	--	--	--	--
New York	x	x	x	x
North Carolina				
North Dakota				
Ohio	x			
Oklahoma	x	x	x	x
Oregon	x	x	x	x
Pennsylvania	x	x	x	x
Rhode Island	x		x	x
South Carolina	x	* *	x	x
South Dakota			x	x
Tennessee	x	x	x	x
Texas	x	x	x	x
Utah	x	x	x	x
Vermont			x	x
Virginia				
Washington	x	x	x	x
West Virginia				x
Wisconsin	x	x	x	x
Wyoming			x	x
TOTAL	33	26	37	39

SOURCE: Georgetown University Health Policy Institute

*States that answered "yes" have made efforts to present information in a manner that can be understood by people reading at relatively low reading levels.

** South Carolina planned to translate the application into Spanish in the future.

Table 6. The Availability of Full Medicaid and Medicare Savings Programs Applications in Several Languages for the Elderly and Individuals with Disabilities, 2002

STATE	Applications for Full Medicaid Benefits	Applications for the Medicare Savings Programs
California	Armenian, Chinese, Farsi, Hmong, Khmer, Korean, Laotian, Russian, and Spanish	Spanish
Florida	Spanish and Creole	Spanish
Minnesota	Arabic, Hmong, Khmer, Laotian, Oromo, Russian, Serbo-Croatian, Somali, Spanish, and Vietnamese	Arabic, Hmong, Khmer, Laotian, Oromo, Russian, Serbo-Croatian, Somali, Spanish, and Vietnamese
New Hampshire	Bosnian, Spanish	Not translated
Oregon	Spanish, Russian, and Vietnamese	Spanish, Russian, and Vietnamese
Texas	Spanish	Spanish
Washington	Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese	Cambodian, Chinese, Korean, Laotian, Russian, Somali, Spanish, and Vietnamese
Wisconsin	Hmong, Russian, and Spanish	Hmong, Russian, and Spanish

SOURCE: Georgetown University Health Policy Institute

Accommodating People with Limited Literacy Skills

Written program applications can be daunting for people with limited literacy skills. Adults with low literacy skills rely heavily on visual cues, verbal explanations, demonstration of tasks, and enhanced memory and listening skills to learn (Barents Group LLC, 1999a). When opportunities for face-to-face meetings or oral explanations are not available, persons with limited literacy skills may not be able to access needed services and benefits.

The 1992 National Adult Literacy Survey found that 40 to 44 million adults read below the fifth-grade level and had difficulty using certain reading, writing, and computational skills necessary for daily functioning. A third of the respondents who reported reading below the fifth-grade level were 65 and older, and 25 percent were immigrants who may have had limited or no English proficiency (Kirsch, Jungeblut, Jenkins, and Kolstad, 2002).

Federal Requirements

Although there are no specific federal requirements regarding the reading level for Medicaid applications, a presidential memorandum issued on June 1, 1998, requested that, by October 1, 1998, all new federal documents that explain how to obtain a benefit or service be written in plain language. Federal documents created prior to October 1, 1998 were to be rewritten in plain language by January 1, 2002. Plain-language documents were defined as those that have logical organization, use common words except for necessary technical terms, and have easy-to-read design features (U.S. President, 1998).

In 1999, CMS produced a technical assistance tool, *Writing and Designing Print Materials for Beneficiaries: A Guide for State Medicaid Agencies,* to help states create easy-to-understand information that accounts for all literacy levels (Block, 1999). The guide provides information on how to do the following:

- Plan, develop, and distribute information materials;
- Evaluate documents for effectiveness;
- Provide the appropriate amount of context to help the applicant understand the information;
- Write clear and simple text; and
- Reinforce key messages through effective layout, type styles, color, illustration, and graphic design.[3]

Findings: Accommodating Low Literacy Levels

Survey results suggest that states understood the importance of creating program applications that enabled people with limited or no English proficiencies and low literacy levels to easily apply for benefits (Table 5).

- Thirty-seven states had designed the full Medicaid application and 39 states had designed applications for Medicare Saving Programs to accommodate applicants with low literacy levels.
- Some states used formal methods to accommodate lower reading levels. For example, Arizona reported that it had a contract with a consulting firm to evaluate notices and forms. The Medi-Cal application in California was evaluated by focus groups to ensure clear and understandable language.
- Other states reported having staff members with some knowledge of literacy issues. For example, in Alabama, one staff member attended a workshop on developing materials for people with low literacy levels.
- Some states made sure that staff members who made direct client contact were included in the application review process because of their firsthand knowledge of applicants' potential problems, including limited literacy skills.

[3]The guide also includes a checklist that can be copied and used to assess print materials (McGee, 1999). In 2000, CMS awarded contracts to MAXIMUS Center for Health Literacy and Communication Technologies to develop model notices and applications for the English and Spanish versions of a joint Medicaid/SCHIP application, a Medicaid-only family application, and a joint Medicaid/TANF/Food Stamps application that would be easier to read and use (Mann, 2000).

- Most states reported using a software program or the option in Microsoft Word to check the reading grade level of documents. Among the states that scored applications for reading level, the range was from third grade to twelfth grade. Twenty-one states aimed for an eighth-grade level or lower.
- Paper forms were not used in Kentucky for full Medicaid or the Medicare Savings Programs. Rather, eligibility workers asked applicants questions and then entered the responses directly into a computer. This interactive process was helpful for clients who had difficulty with reading and comprehension, but it did require face-to-face interviews for all applicants.

III. DOCUMENTATION REQUIREMENTS

Eliminating or Decreasing Documentation Requirements

In making eligibility determinations for the Medicaid program, most states require applicants to submit various documents to verify information they provide about income and/or assets. One reason for this requirement is the belief that applicants will report their income and resources more accurately if they are required to provide substantiating documentation (Nemore, 1999). Some states also require documents that verify date of birth, residency, family composition, and insurance status.

Verification requirements may pose a barrier for some applicants, particularly those who are not accustomed to applying for public benefits and may be wary of providing large amounts of personal information. Applicants may also be discouraged if the required documents are not readily available. In focus groups, seniors noted that having to submit so many documents for verification of income presented difficulties, particularly if they could not locate the correct documents or had to make copies of them (Perry, Kannel, and Dulio, 2002). Cost may also be a factor if there is a photocopying charge (Cohen Ross and Jacobson, 1998). Documentation requirements have been shown to cause delays in processing applications. A letter from CMS to state Medicaid directors reported that one state had found a direct link between extensive verification requirements and a significant number of denials and terminations of individuals or families who did not return verification information but were otherwise eligible (Westmoreland, 2000c).

In states where verification documents are not required, applicants are allowed to make self-declarations about the information they provide. Typically, this information is provided under penalty of perjury. Some states have concluded that the public data source of income information—the Income and Eligibility Verification System (IEVS)—is sufficient, and therefore do not require income documentation.

A survey of state officials on their documentation practices related to families and children found that caseworker productivity increased as a result of implementing a “self-declaration” policy. In addition, several state officials reported that self-declaration of income allowed for more timely eligibility determinations (Cohen Ross and Cox, 2002).[4] There was also evidence from states that had implemented self-declaration policies in programs and post-eligibility evaluations for children that the methods were efficient and accurate. For example, a year-long review of children’s applications for Medicaid in Idaho found that more than 99 percent of approved applications were accurate (Cox, 2001). According to an analysis from the Southern Institute on Children and Families, Georgia, which eliminated its income verification requirement for families with income below the federal poverty several years ago, had not experienced increased error rates.

[4]In a survey of practices related to families and children, 13 states did not require families to provide verification documents with respect to income (Cohen Ross and Cox, 2002). State officials reported that accepting self-declaration of income had been successful. Previously, applications were frequently placed in a pending category because caseworkers did not have the necessary verification documents to determine eligibility.

Self-declaration policies can ease the enrollment process for both applicants and eligibility workers (Cox, 2001; Smith, Ellis, and Chang, 2001). The administrative burden associated with making eligibility determinations is reduced if eligibility workers do not have to review documents, contact applicants regarding missing documents, and close and reopen cases when documents are not provided during a certain period.

States' experiences indicate that error rates do not increase when requirements for verification documents are eliminated for Medicare Savings Programs. For example, findings from case studies of Medicare Savings Programs indicate that states that have waived documentation requirements and rely instead on automated collateral verification systems to detect inaccuracies do not report an increase in errors or an increase in fraud (Glaun, 2002).

In addition to meeting income requirements for Medicaid eligibility, applicants may be required to demonstrate that the value of their assets does not exceed a specified amount**.** Under Section 1902(r)(2) of the Medicaid statute, states have the option to use income and resource (or asset) methodologies that are less restrictive than those used by comparable cash assistance programs in determining eligibility for most Medicaid eligibility groups (CMS, 2001b). States that use less restrictive asset methodologies may allow applicants who have more assets to qualify, or they may use a methodology that essentially exempts all assets.

In a 2002 survey of officials in nine states and the District of Columbia where asset tests for families had been eliminated, officials were asked about their reasons for, the process of, and the consequences of eliminating the asset test. The respondents indicated that eliminating the asset test not only simplified the process, but also improved the productivity of their eligibility workers, and hence, lowered the cost of eligibility determinations. In Oklahoma, for example, officials reported estimated annual savings of $1.2 million in state funds after eliminating the asset test for families (Smith, Ellis, and Chang, 2001). Forty-four states, including the District of Columbia, had eliminated asset tests when determining eligibility for children in Medicaid and separate SCHIP programs. This policy reduced the complexity of the enrollment process considerably. In states where eligibility determinations were made on the basis of assets, program application forms were longer, the number of verification documents required was greater, and the time required to process applications increased (Cohen Ross and Cox, 2002).

Other studies provide evidence that people who qualified for Medicaid based on income tended not to have substantial assets (Summer and Friedland, 2002). According to one study, more than half (57 percent) of all Medicare beneficiaries with incomes below the poverty level had less than $1,500 in assets that would be counted if they applied for assistance from public programs (Moon, Friedland, and Shirey, 2002). Other studies have found that people who participated in public assistance programs tended to be less well-off financially than those who were eligible but did not apply (Barents Group LLC, 1999b; David and MacDonald, 1992; GAO, 1999; McGarry, 1995; Neumann, Bernardin, Evans, and Bayer, 1995; Quinn, 1999). Finally, studies have found that people who were eligible for public assistance and owned a home, or whose income or assets were relatively higher, were less likely to apply for assistance (Barents Group LLC, 1999b; Coe 1985; Drazga, Upp, and Reno, 1982; McGarry, 1995; Quinn, 1992).

Federal Requirements

The only requirement imposed by federal law regarding documentation for Medicaid is that states verify immigration status for applicants who are not U.S. citizens or nationals (CMS, 2001a). Noncitizens must provide proof of alien or immigration registration from the Bureau of Citizenship and Immigration Services, or other documentation that is considered reasonable evidence of satisfactory immigration status.[5] Federal law does not require applicants to provide documents to verify any other information submitted for a Medicaid eligibility determination. When states require documents, they are responsible for informing applicants about the requirements (CMS, 2001a).

States are required to have a Medicaid Eligibility Quality Control System (MEQC) to collect data on eligibility, beneficiary liability, and claims payments. The primary objective of the system is to identify and reduce dollar losses as a result of erroneous eligibility determinations (CMS, n.d.). When state officials consider making policy changes to reduce requirements for verification, they often express concern that the change may increase errors and lead to sanctions from the federal government. In response to these concerns, CMS provided specific guidance about the relationship between the MEQC program and state efforts to simplify the application process (Westmoreland, 2000c). If states use the MEQC pilot program option, error rates are frozen so that there is no penalty if the experiments are not successful. CMS specifically suggested that states can design a MEQC pilot program to examine the effect of eliminating verification requirements (Westmoreland, 2000c).

Federal law requires states to use the IEVS to verify income for the Medicaid program. This verification process must occur regardless of whether applicants are asked to provide documentation or are allowed to self-declare their income and assets. In addition, federally funded public assistance and unemployment agencies are required to exchange information with each other and to request and use information on net earnings and unearned income from the Internal Revenue Service (IRS), benefit information and other income and wage data from the Social Security Administration (SSA), and information on state wages and unemployment insurance benefits (Income and Eligibility Verification System, 2003).[6]

Under IEVS rules, the agency must inform applicants in writing, at the time of application, that information from other agencies will be requested. Information received for IVES purposes must be used within 30 calendar days to determine eligibility (Income and Eligibility Verification System Rule, 2003). Agencies are not required to use the IEVS system for aged, blind, or disabled Medicaid recipients who receive SSI benefits, if the SSA determines their eligibility under Section 1634 of the Social Security Act (Income and Eligibility Verification System Rule, 2003).

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[5] The Personal Responsibility Work Opportunity Reconciliation Act of 1996 created two categories of legal immigrants for Medicaid eligibility—those who immigrated prior to August 22, 1996, and those who immigrated on or after that date. Immigrants who arrived before August 22, 1996 are generally eligible for public benefits, including the Medicaid program. Those who entered the country on or after that date are not eligible for any federal public benefits until they have lived in the United States for five years. The 1997 Balanced Budget Act (BBA) created an exception to this five-year rule for immigrants who qualify for SSI on the basis of age or disability. The BBA also restored eligibility to all immigrants who were receiving SSI on August 22, 1996 (Fremstad, 2002; Schneider, Elias, Garfield, Rousseau, and Wachino, 2002).

[6] Although all states have access to the information from the required agencies, the methods of data exchange vary. For example, information from the Social Security Administration can be provided through data matches or through online queries. States that use data matches provide an individual's social security number, and resulting matched information is returned through the computer system or printed copies are sent to the agency. This may occur only once or twice a month. Online query systems allow the Medicaid agency to enter the individual's social security number and receive verification information, usually within 24 to 48 hours. Some states have direct interface systems that allow an eligibility worker to log on to another agency's system to retrieve the information immediately.

Findings: Documentation Requirements

Almost all states required elderly and disabled Medicaid and Medicare Savings Programs applicants to provide documents that verified income and assets. Some states also required documents to verify date of birth and other personal statistics in addition to the documentation required by the federal government to verify immigration status. The survey provided the following details about state practices (Table 7):

- With respect to full Medicaid benefits, five states did not require documentation to verify income and seven states did not require documentation to verify assets.
- Twelve states did not require documentation to verify income, and 17 states did not require documentation to verify assets for Medicare Savings Programs.
- Hawaii, Vermont, and Washington accepted self-declaration for income or assets for both the full Medicaid program for the elderly and people with disabilities and Medicare Savings Programs. These states reported extensive use of the secondary verification. Clients were required to bring in documentation only if verification through existing data sources was not possible, or if discrepancies were found. In California, Mississippi, Pennsylvania, and South Dakota, eligibility workers used the IEVS to obtain information if applicants had trouble obtaining the necessary verification documents.

Table 7. Income and Asset Documentation Requirements for Full Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities, 2002

	Are Documents Required to Verify Income?		Are Documents Required to Verify Assets?	
	Full Medicaid	**Medicare Savings Programs**	**Full Medicaid**	**Medicare Savings Programs**
STATE	NO	NO	NO	NO
Alabama				x
Alaska				
Arizona			x	x
Arkansas		x		x
California				
Colorado				
Connecticut		x		x
Delaware			x	x
District of Columbia				
Florida		x		x
Georgia		x		x
Hawaii	x	x	x	x
Idaho				
Illinois		x		x
Indiana				
Iowa				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland				
Massachusetts				
Michigan				
Minnesota			x	x
Mississippi				x
Missouri				
Montana				
Nebraska				
Nevada	x		x	
New Hampshire				
New Jersey		x		x
New Mexico	--	--	--	--
New York				x
North Carolina				
North Dakota				
Ohio				
Oklahoma				
Oregon				
Pennsylvania				
Rhode Island		x		x
South Carolina				
South Dakota				
Tennessee				
Texas		x		x
Utah				
Vermont	x	x	x	x
Virginia				
Washington	x	x	x	x
West Virginia				
Wisconsin	x	x		
Wyoming				
TOTAL	5	12	7	17

SOURCE: Georgetown University Health Policy Institute

IV. APPLICATION SUBMISSION AND REVIEW

Approaches to Simplifying the Application Submission and Review Process

The following practices can make a difference in the ease with which applications are submitted and the time elapsed before applicants know about their enrollment status:

- Timely application processing;
- Timely notification of applicants;
- Using dedicated staff to process applications for Medicare Savings Programs;
- Eliminating face-to-face interview requirements;
- Making transportation vouchers and extended office hours available; and
- Providing options for submitting applications.

Application Processing

Prompt notification of eligibility is important because applicants can begin using their Medicaid benefits as soon as they are notified that they are eligible. One of the immediate benefits of timely notification of applicants for Medicare Savings Programs is that they can begin receiving assistance with their Medicare premiums. People on fixed incomes can use money that would otherwise be needed to pay premiums to purchase food, prescription medications, or other necessities. Prompt notification is also important for applicants who are denied eligibility, because it allows them to seek alternative resources and gives them the opportunity to appeal the denial in a timely manner.

Federal Requirements

Federal regulations require that Medicaid eligibility be determined and proper notice be provided within 45 days of the date of application for elderly persons, and within 90 days for people with disabilities (Timely Determination of Eligibility Rule, 2002). Federal regulations also require states to provide clear and understandable notices to applicants who are denied Medicaid benefits. The notice must inform applicants of the denial, the reasons for it, and their appeal rights (Notice of Agency's Decision Concerning Eligibility Rule, 2002).

Findings: Application Processing

State practices demonstrated an awareness of the importance of speedy application processing and timely notification (Table 8):

- All states reported that they processed applications within the required time frames, but some reported that they generally processed applications more quickly for elderly applicants (Table 8).

Table 8. Time Frame for Informing the Elderly and Individuals with Disabilities about Full Medicaid and Medicare Savings Programs Eligibility, 2002

	Full Medicaid		Medicare Savings Programs	
State	**Applicants Are Informed within 30 Days or Less**	**Applicants Are Informed within 45 Days**	**Applicants Are Informed within 30 days or Less**	**Applicants Are Informed within 45 Days**
Alabama		x	x	
Alaska	x		x	
Arizona		x		x
Arkansas		x		x
California		x		x
Colorado		x		x
Connecticut		x		x
Delaware	x		x	
District of Columbia		x		x
Florida		x		x
Georgia		x	x	
Hawaii	x		x	
Idaho	x		x	
Illinois		x		x
Indiana		x		x
Iowa	x		x	
Kansas		x	x	
Kentucky	x		x	
Louisiana	x		x	
Maine	x		x	
Maryland	x		x	
Massachusetts		x		x
Michigan		x		x
Minnesota		x		x
Mississippi		x		x
Missouri		x		x
Montana	x		x	
Nebraska		x		x
Nevada	x			x
New Hampshire		x		x
New Jersey	x		x	
New Mexico	--	--	--	--
New York		x		x
North Carolina		x		x
North Dakota		x		x
Ohio		x		x
Oklahoma	x		x	
Oregon		x		x
Pennsylvania	x		x	
Rhode Island	x		x	
South Carolina		x	x	
South Dakota		x		x
Tennessee		x		x
Texas		x		x
Utah	x		x	
Vermont	x		x	
Virginia		x		x
Washington		x		x
West Virginia	x		x	
Wisconsin	x		x	
Wyoming		x		x
TOTAL	19	31	22	28

SOURCE: Georgetown University Health Policy Institute

- Applications for full Medicaid coverage were processed in 30 days or less, on average, in 19 states.
- Applications for Medicare Savings Programs were processed in 30 days or less, on average, in 22 states.
- Montana had instituted a timeliness report, and eligibility workers were held to the timeliness requirement. Montana officials reported that the time frame for denials was generally longer than for approvals because people were given as much time as possible to complete the application process; nevertheless, a number of the denials were the result of incomplete applications.

Use of Dedicated Staff

Staff whose only job is to process applications for Medicare Savings Programs (i.e., dedicated staff) develop expertise in applying a particular set of programs requirements. The use of dedicated staff may also reduce the amount of time required to process Medicare Savings Programs applications, which are likely to be less complicated than applications for full Medicaid coverage.

Federal Requirements

There are no federal requirements regarding separate staff to review and process applications for specific programs.

Findings: Use of Dedicated Staff

Most states did not employ separate staff to review and process applications. Notable exceptions were six states—California, Delaware, Massachusetts, New Jersey, New York, and Oklahoma—and the District of Columbia that had separate staff to review applications for Medicare Savings Programs. These respondents noted that, even though they had dedicated staff for processing applications, people could apply for benefits at any location.

Face-to-Face Interview Requirements

Historically, when Medicaid eligibility was linked to receipt of cash assistance, applicants were required to appear in person at the Medicaid office to apply for benefits. This practice is known as face-to-face interviews. Certain barriers, such as a lack of transportation or mobility limitations, are associated with this requirement. Applicants may not drive or may lack access to other private transportation, and they may have difficulties using public transportation. Special public transportation for people with disabilities is available only in some locations, and then, riders may have to adjust their schedules to conform to the availability of transportation services.

A study of 1,255 low-income parents found that 419 had never tried to enroll their children in the Medicaid program. The inaccessibility of the office was a problem for many of the respondents. Specifically, 44 percent said the office was not open when they could go, and 39 percent said the office was too far away. A substantial percentage (42 percent) of the parents said they feared that they would be treated badly by Medicaid workers (Perry, Smith, Smith, and Chang, 2000). In a survey of community health center patients, respondents said they were reluctant to go to a

welfare office because they anticipated long waits or discourteous treatment (Stuber, Maloy, Rosenbaum, and Jones, 2000).

In addition to easing the enrollment process for clients, eliminating face-to-face interview requirements can decrease the amount of time eligibility workers need to spend on each application. Thus, administrative costs can be reduced, and eligibility workers' time can be used to help applicants in other ways, such as providing more individualized attention or reaching out to certain hard-to-enroll populations (Cohen Ross, 2001; Ellwood, 1999; Nemore, 1999; Schulte, Pernice, and Rosenthal, 2000; Schwalberg, Hill, Bellamy, and Gallagher, 1999; Smith, Ellis, and Chang, 2001).

Although the elimination of the face-to-face interview requirements is an advantage for many applicants, those who require assistance when they apply for benefits should have access to it. For example, in focus groups of low-income elderly people, some respondents stated that, because the applications were complicated, they appreciated assistance when completing the forms (Perry, Kannel, and Dulio, 2002).

Federal Requirements

There are no federal requirements for face-to-face interviews for Medicaid applicants (CMS, 2001a).

Findings: Face-to-Face Interviews

More than half the states responding to the survey required a face-to-face interview for full Medicaid, while a few required an interview for Medicare Savings Programs. Survey findings (Table 9) revealed that 18 states required face-to-face interviews for full Medicaid, and 9 states required face-to-face interviews for Medicare Savings Programs. It is instructive to note that almost all state Medicaid programs (47) had eliminated the face-to-face interview requirement for children as of January 2002. Many states had eliminated this requirement for parents as well (Cohen Ross and Cox, 2002).

Access to the Medicaid Office

Eligibility offices are typically open on weekdays between 8 A.M. and 5 P.M. Keeping offices open later in the evening or on weekends may help people who are unable to get to the office during regular hours. For example, older people and people with disabilities may have to rely on friends or families who have limited flexibility to be away from their jobs. The availability of evening and/or weekend hours may be of great benefit to both the applicant and the person who provides transportation.

Table 9. Face-to-Face Interview Requirements for Full Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities, 2002

	Are Face-to-Face Interviews Required?		Does Medicaid Have Extended Office Hours?	Does Medicaid Offers Transportation Vouchers?
	For Full Medicaid	For Medicare Savings Programs		
State	YES	YES	YES	YES
Alabama				
Alaska	x	x		
Arizona				
Arkansas	x			
California				
Colorado				
Connecticut				
Delaware			x	
District of Columbia	x		x	
Florida	x			
Georgia	x*		x	x
Hawaii				
Idaho			x	
Illinois				
Indiana				
Iowa	x	x		
Kansas				
Kentucky	x	x		
Louisiana				
Maine				
Maryland	x	x		
Massachusetts				
Michigan				
Minnesota			x	
Mississippi			x	
Missouri				
Montana			x	
Nebraska	x			x
Nevada				x
New Hampshire	x	x		
New Jersey	x		x	x
New Mexico	--	--	--	--
New York	x	x	x	
North Carolina	x	x		
North Dakota				
Ohio	x			x
Oklahoma	x	x		
Oregon			x	
Pennsylvania				
Rhode Island				
South Carolina				
South Dakota				
Tennessee			x	
Texas	x			
Utah				
Vermont				
Virginia				
Washington				
West Virginia	x			
Wisconsin				x
Wyoming	x	x	x	
TOTAL	18	9	12	6

SOURCE: Georgetown University Health Policy Institute

* Georgia made a policy change to eliminate face-to-face interviews for all Medicaid applications, but it had not been implemented in the field as of the time of this survey.

Potential applicants often need to access the Medicaid office, either because of face-to-face interview requirements or because they need assistance completing the applications. Transportation vouchers can help low-income applicants by providing free or reduced-cost transportation by bus, taxi, or shuttle. Vouchers do not address other transportation-related difficulties, however. For example, in focus groups of low-income elderly people, respondents noted that finding transportation to the enrollment office was difficult. Others noted that taking the bus with a walker was very difficult (Perry, Kannel, and Dulio, 2002).

Federal Requirements

Federal law does not require Medicaid offices to provide extended office hours or transportation vouchers for applicants. CMS has recommended that states offer extended office hours so that applicants do not have to take time off from work to apply for benefits and that states provide transportation vouchers to help applicants get to interviews (Richardson, 1998).

Findings: Access to the Medicaid Office

Few states reported having extended office hours or offering travel vouchers, even when they required face-to face interviews. Ironically, states that did not have face-to-face interview requirements offered more supportive services to applicants (e.g., extended hours and/or transportation vouchers) than those that required interviews. The following are additional results from the survey regarding the availability of supportive services (Table 9):

- Extended weekend or evening office hours were offered in 12 states. Of the 18 states that required face-to-face interviews for full Medicaid benefits, 5 offered extended hours.
- Of the nine states that required face-to-face interviews for Medicare Savings Programs, only two offered extended office hours.
- Six of the responding states provided transportation vouchers. Of the 18 states that required face-to-face interviews for full Medicaid, 4 offered transportation vouchers.
- Of the nine states that required face-to-face interviews for Medicare Savings Programs, none provided transportation vouchers.
- Among states that did not require face-to-face interviews, seven had extended weekend hours and two provided transportation vouchers.

Options for Submitting Applications

The ability to submit applications by mail, phone, facsimile, or the Internet is convenient for applicants. The availability of these options helps to overcome barriers created by transportation and mobility difficulties, and also makes the application process easier for working people who do not have flexibility in their jobs. Completing the application in familiar and comfortable surroundings may make the process less formidable. Applicants can also get help more easily from family members or volunteers in the community when they are not required to submit the application in person to the Medicaid agency.

Federal Requirements

Federal law requires that Medicaid applications be submitted in writing; however, the method for submission is not specified (Written Application Rule, 1999). Regardless of how the application is submitted, federal law requires states to protect the confidentiality of the applicant and to restrict the use or disclosure of confidential information (State Plans for Medical Assistance, 2003). Therefore, when states use online Medicaid applications, these safeguards must be in place. CMS has outlined an Internet security policy that recommends the use of a specific automatic encryption process (CMS, 1998). All applications are required to be signed by the applicant (Written Application Rule, 1999), but electronic signatures may be authorized by state law (CMS, 2001a).

Findings: Options for Submitting Applications

Internet, telephone, and facsimile options for submitting applications are not widely used. Survey results (Table 10) revealed the following practices:

- All states except New Jersey accepted applications in person for both full Medicaid and Medicare Savings Programs, and the majority of states accepted them by mail.
- Approximately two-thirds of states accepted applications by facsimile.
- Only three states—Oklahoma, Pennsylvania, and Washington—accepted applications online. Minnesota planned to implement an online application process by July 2003.
- In every responding state, the majority of applications were submitted in person or by mail.
- Twenty-nine states were able to estimate the percentage of full Medicaid applications received by each method of submission, and 28 states were able to do so for the Medicare Savings Programs. However, in many states this information was not available. Among the states able to estimate how applications were received, not more than 15 percent of applications were received by facsimile and not more than 5 percent were received by phone or online for full Medicaid; similar results applied to the Medicare Savings Programs.
- Among the 29 responding states, 14 reported that half or more of the applications for full Medicaid benefits were submitted in person, and another 14 states reported that at least half of applications for full Medicaid benefits were submitted by mail.
- With regard to Medicare Savings Programs, among 28 responding states, 10 reported that half or more of the applications received were submitted in person, and 17 reported that half or more were submitted by mail.

Table 10. Options for Submitting Full Medicaid and Medicare Savings Programs Applications for the Elderly and Individuals with Disabilities, 2002

	Full Medicaid					Medicare Savings Programs				
STATE	In Person	By Mail	By Fax	By Phone	Online	In Person	By Mail	By Fax	By Phone	Online
Alabama	x	x				x	x			
Alaska	x	x				x	x			
Arizona	x	x	x			x	x	x		
Arkansas	x	x	x			x	x	x		
California	x	x	x	x		x	x	x	x	
Colorado	x	x				x	x			
Connecticut	x	x	x			x	x	x		
Delaware	x	x	x	x		x	x	x	x	
District of Columbia	x	x				x	x			
Florida	x	x	x	x		x	x	x	x	
Georgia	x	x	x	x		x	x	x	x	
Hawaii	x	x	x			x	x	x		
Idaho	x	x	x			x	x	x		
Illinois	x	x	x			x	x	x		
Indiana	x	x	x			x	x	x		
Iowa	x	x	x			x	x	x		
Kansas	x	x	x			x	x	x		
Kentucky	x			x		x			x	
Louisiana	x	x	x	x		x	x	x	x	
Maine	x	x	x			x	x	x		
Maryland	x					x				
Massachusetts	x	x				x	x			
Michigan	x	x				x	x			
Minnesota	x	x	x	x		x	x	x	x	
Mississippi	x	x	x	x		x	x	x	x	
Missouri	x	x				x	x			
Montana	x	x	x			x	x	x		
Nebraska	x	x	x			x	x	x		
Nevada	x	x	x	x		x	x	x	x	
New Hampshire	x	x				x	x			
New Jersey	x						x	x		
New Mexico	--	--	--	--	--	--	--	--	--	--
New York	x	x	x			x	x	x		
North Carolina	x					x				
North Dakota	x	x				x	x			
Ohio	x	x	x			x	x	x		
Oklahoma	x	x	x		x	x	x	x		x
Oregon	x	x	x			x	x	x		
Pennsylvania	x	x	x		x	x	x	x		x
Rhode Island	x	x				x	x			
South Carolina	x	x	x	x		x	x	x	x	
South Dakota	x	x	x			x	x	x		
Tennessee	x	x	x	x		x	x	x	x	
Texas	x	x				x	x			
Utah	x	x	x	x		x	x	x	x	
Vermont	x	x	x			x	x	x		
Virginia	x	x	x			x	x	x		
Washington	x	x	x		x	x	x	x		x
West Virginia	x					x	x			
Wisconsin	x	x	x	x		x	x	x	x	
Wyoming	x	x				x	x			
TOTAL	50	45	33	13	3	49	47	34	13	3

SOURCE: Georgetown University Health Policy Institute

***** Minnesota accepted applications online as of July 2003.

V. IDENTIFYING AND ASSISTING APPLICANTS

Alternative Approaches to Submitting Applications and Assisting Applicants

There are several steps that states can take to accommodate people who need extra assistance with the application process. Arrangements may be made so that people can apply at more convenient locations, get assistance with their applications, or get additional information about eligibility requirements. Approaches that are used to accommodate people who may need extra assistance include the following:

- Outstationing eligibility staff;
- Giving professionals outside the Medicaid program authority to assist applicants; and
- Using screening tools for potential applicants.

Outstationing Eligibility Staff

Outstationing enables people to apply for benefits at locations other than the Medicaid or social services office. State employees are permanently located or periodically sent to places such as hospitals or health centers to take applications and assist with the application process.

Federal Requirements

Federal law requires states to outstation eligibility workers and accept and process Medicaid applications for children and pregnant women at disproportionate share hospitals (DSH)[7] and federally qualified health centers (FQHCs). The mandate to outstation eligibility workers does not apply to older people and people with disabilities, but states are encouraged to outstation eligibility workers for these populations as well (Establishment of Outstation Locations to Process Applications for Certain Low-Income Eligibility Groups, 1999).

States may use outstation locations other than DSH hospitals and FQHCs. A federally approved amendment to the Medicaid State Plan is required to outstation workers at such locations. Outstation locations are required to take applications, provide information and referrals, obtain required documentation, ensure that the application form is complete, and conduct any required interviews. This requirement does not include evaluating the information and making an eligibility determination, but states can outstation workers to make eligibility determinations *if* the workers are state employees (Establishment of Outstation Locations Rule, 1999).

Guidance from CMS reminds states that program enrollment can be facilitated if people are able to apply for Medicaid benefits at the site where they receive health care services (Westmoreland, 2001). Federal matching funds are available for outstationing costs incurred at regular outstation locations and at infrequently used and optional locations. The federal government reimburses 50 percent of the cost of taking and processing applications, including salaries, fringe benefits,

[7] Disproportionate share hospitals are those that serve a "disproportionate share" of low-income or uninsured patients. These hospitals receive extra federal matching funds through the Medicaid program.

travel, training, equipment, and space directly attributable to outstationing activities (Westmoreland, 2001).

Findings: Outstationed Workers

The survey results revealed that many states permitted outstationed workers to assist applicants. Highlights from survey findings include the following (Table 11):

- Thirty-one states reported that they outstationed eligibility staff to serve elderly applicants and applicants with disabilities for the full Medicaid program. Twenty-nine states reported that they outstationed staff for Medicare Savings Programs.
- The number of locations and share of applications submitted from outstationed workers varied. In five states, the number of locations for outstationed workers was not known. Four other states reported that counties had discretion regarding the number of sites. Eight states reported having 10 or fewer outstation locations for elderly applicants and applicants with disabilities.
- Other states had numerous outstation sites. In Louisiana, for example, outstationed workers were located at 403 sites. Utah had workers at 127 sites, Michigan had 119 sites, and Georgia had 63 sites.
- Many states, particularly those with multiple sites, contracted with other organizations to provide enrollment assistance.
- Seven of the states with outstationed workers knew what proportion of the applications came from outstation sites. Louisiana and Utah reported that about half the applications they received from elderly people or people with disabilities were from outstationed workers. The proportion in Wyoming was one-fifth of applications. The other four states that reported this information said that 10 percent or less of the applications came from outstationed workers.
- Hospitals were the most common locations for outstationed workers. Many states also reported that eligibility workers were outstationed at health clinics and community services agencies. Homeless shelters and food pantries were other locations mentioned.
- Some states went to substantial effort to outstation workers. For example, in Delaware, an "Elder Information" van transported eligibility workers to different communities. Montana reported that during migrant season, eligibility workers were sent to the cherry orchards, and in Texas, workers visited border communities. Minnesota placed eligibility workers at several community sites to conduct enrollment for Medicare Savings Programs. The sites included places of worship, libraries, senior centers, and HUD sites. Several of the sites were supported in part by a Dual Eligible Partnership Grant. [8]

[8] CMS awarded grants to six states in 2000 to promote enrollment in Medicare Savings Programs.

Table 11. States that Outstation Full Medicaid and Medicare Savings Programs Eligibility Workers to Assist the Elderly and Individuals with Disabilities, 2002

	Does Medicaid Outstation Eligibility Workers for People Who Are Elderly or Have Disabilities?	
	Full Medicaid	**Medicare Savings Programs**
STATE	YES	YES
Alabama		
Alaska		
Arizona		
Arkansas	x	
California	x	x
Colorado	x	x
Connecticut	x	x
Delaware	x	x
District of Columbia	x	x
Florida		
Georgia	x	x
Hawaii		
Idaho		
Illinois		
Indiana		
Iowa	x	x
Kansas	x	x
Kentucky		
Louisiana	x	x
Maine		
Maryland		
Massachusetts		
Michigan	x	x
Minnesota	x	x
Mississippi	x	x
Missouri	x	x
Montana	x	x
Nebraska		
Nevada		
New Hampshire		
New Jersey	x	x
New Mexico	--	--
New York	x	x
North Carolina	x	x
North Dakota	x	x
Ohio		
Oklahoma	x	x
Oregon	x	x
Pennsylvania	x	x
Rhode Island		
South Carolina	x	x
South Dakota		
Tennessee	x	x
Texas	x	x
Utah	x	x
Vermont		
Virginia	x	x
Washington	x	
West Virginia	x	x
Wisconsin	x	x
Wyoming	x	x
TOTAL	31	29

SOURCE: Georgetown University Health Policy Institute

Delegating Authority to Assist Applicants

State Medicaid agencies may give some authority to volunteers or employees of community-based or other agencies who are trained to assist with the application process. They are sometimes called "deputized" workers. Recruiting community workers or groups who are trusted by potential enrollees may reduce some of the barriers to enrollment (Patterson 2000; Schwalberg, Hill, Bellamy, and Gallagher, 1999).

These workers can be trained to help applicants complete the applications and then hand-deliver, mail, or electronically transfer them to the Medicaid office for eligibility determination. Deputized workers can also identify people who may be eligible for Medicaid benefits and conduct an initial screening for eligibility (Barents Group LLC, 1999b; Cohen Ross, 2001; Rosenbach and Lamphere, 1999; Schulte, Pernice, and Rosenthal, 2000). Across the country, Area Agencies on Aging (Triple A's) and State Health Insurance Assistance (SHIP) programs actively provide information about the availability of Medicaid benefits and assistance with enrollment. This approach has the potential to provide assistance and increase program enrollment among older people, but without adequate funding and training for this function, the potential is limited (Glaun, 2002).

Federal Requirements

There are no specific federal regulations regarding deputized workers. However, if deputized workers are part of an outstation agreement, federal regulations related to outstationing apply to them. Regulations guiding outstationing state that the Medicaid agency can use provider or contractor employees and volunteers who have been properly trained to staff outstation locations. Provider and contractor employees and volunteers are allowed to take applications, assist applicants in completing the application, provide information and referrals, obtain required documentation to complete processing of the application, check that the information on the application form is complete, and conduct necessary interviews. They are not allowed to evaluate the information on the application or documentation or to make a determination of eligibility (Establishment of Outstation Locations Rule, 1999).

Findings: Assisting Applicants

According to the state survey of practices affecting elderly or disabled persons applying for Medicaid or Medicare Savings Programs, the most common type of assistance that deputized outstationed workers provided was helping applicants complete their forms (Table 12). Other highlights of survey findings include the following:

- Deputized workers were given some authority to assist people with applications for the full Medicaid program in 22 states, and for Medicare Savings Programs in 28 states. The most common type of assistance was help in completing applications.
- Twelve states -- some that required face-to-face interviews and some that provided them by request -- indicated that deputized workers were allowed to conduct face-to-face interviews.
- Organizations other than the Medicaid agency were allowed to accept applications in 12 states, and in 2 states, these organizations also helped process applications. Deputized workers also helped applicants obtain verification documents in several states.

Table 12. States that Delegate Authority to Help Enroll the Elderly and Individuals with Disabilities in Full Medicaid and Medicare Savings Programs, 2002

	Does Medicaid Deputize People (Train People Outside the Program) and Give Them Authority to Help with Enrollment?		If Yes, What Functions Do They Perform?			
	Full Medicaid	Medicare Savings Programs	Help Complete Applications	Conduct Face-to-Face Interviews	Accept Applications	Help Process Applications
STATE	YES	YES				
Alabama			x	x	x	x
Alaska	x	x	x	x	x	
Arizona	x					
Arkansas						
California	x	x	x			
Colorado	x	x	x	x	x	
Connecticut		x	x			
Delaware						
District of Columbia						
Florida						
Georgia	x	x	x	x	x	
Hawaii	x	x	x	x		
Idaho						
Illinois	x	x	x			
Indiana		x	x	x	x	
Iowa						
Kansas						
Kentucky						
Louisiana	x	x	x	x	x	
Maine	x	x	x			
Maryland		x	x	x		
Massachusetts						
Michigan	x	x	x			
Minnesota	x	x	x			
Mississippi						
Missouri	x	x	x			
Montana	x	x	x			
Nebraska	x	x	x	x	x	
Nevada						
New Hampshire		x	x	x	x	
New Jersey		x	x			
New Mexico	--	--	--	--	--	--
New York	x	x	x	x	x	
North Carolina						
North Dakota	x	x	x			
Ohio						
Oklahoma						
Oregon						
Pennsylvania	x	x	x		x	
Rhode Island	x	x	x			x
South Carolina		x	x			
South Dakota	x	x	x	x	x	
Tennessee						
Texas						
Utah	x	x	x		x	
Vermont						
Virginia						
Washington	x	x	x			
West Virginia		x	x			
Wisconsin	x	x	x			
Wyoming						
TOTAL	22	28	29	12	12	2

SOURCE: Georgetown University Health Policy Institute

Screening Tools

Screening tools can be used to obtain a preliminary idea of whether persons are eligible for Medicaid benefits. Because screening tools usually do not require users to provide personal information such as names or social security numbers, potential applicants can learn about eligibility requirements for different programs before they actually apply.

Some screening tools consist of charts that help applicants understand eligibility rules. Other tools provide worksheets that help applicants determine whether they are financially eligible by helping them count income and assets and deduct any exemptions. Medicaid agencies and other programs or organizations can create screening tools and promote their use by making them readily available to potential applicants and organizations that routinely have contact with potential applicants. Some screening tools are available electronically; while they are helpful, many potential applicants do not have access to computers or do not have the skills to use them. Therefore, the tools must be offered in other forms as well.

Potential program participants also can be identified when Medicaid programs work with other programs that serve the low-income elderly and people with disabilities. For example, people participating in state-funded pharmacy assistance programs may be eligible for Medicaid benefits as well. In New Jersey, all participants in the prescription drug program were screened for eligibility in the Medicare Savings Programs. Those who appeared eligible were sent an explanatory letter and a short application form partially completed based on information they provided for the drug program. They were asked to complete the remaining questions and return the form if they wanted to apply for the Medicare Savings Programs (Nemore, 1999). In Minnesota, the eligibility rules and enrollment for the pharmacy assistance programs and the Medicare Savings Programs were linked.

Federal Requirements

There are no federal requirements regarding the use of screening tools.

Findings: Availability of Screening Tools

More than half of the reporting states had developed screening tools, and many made them available in community settings (Table 13). Other survey findings include the following:

- Screening tools were available in 31 states.
- Six states reported that the Medicaid program offered screening tools that had been developed by other agencies and organizations.

Table 13. States that Have Developed and Made Screening Tools Available for the Elderly and Individuals with Disabilities, 2002

	Have Screening Tools Been Developed by Medicaid?	Have Screening Tools Been Developed by Other Agencies?	Are Screening Tools Available Online? If Yes, Where?
STATE	YES	YES	YES
Alabama	x		
Alaska		x	
Arizona	x	x	www.acchhs.state.az.us
Arkansas			
California	x		
Colorado			
Connecticut			
Delaware	x		
District of Columbia			
Florida	x		ww5.myflorida.com/CF_web/myflorida2/healthhuman/ESS
Georgia			
Hawaii			
Idaho	x		
Illinois			
Indiana	x*		
Iowa			
Kansas			
Kentucky	x		
Louisiana	x		
Maine	x		www.state.me.us/dhs/beas/health.htm
Maryland			
Massachusetts			
Michigan	x		
Minnesota	x	x	
Mississippi	x		
Missouri	x		
Montana			
Nebraska			
Nevada			
New Hampshire	x		
New Jersey	x	x	
New Mexico	--	--	
New York	x		
North Carolina	x		
North Dakota	x		
Ohio	x		
Oklahoma	x		
Oregon			
Pennsylvania	x		
Rhode Island	**	x	
South Carolina	x		
South Dakota	x		
Tennessee	x	x	www.tennesseeanytime.org
Texas	x		www.dhs.state.tx.us
Utah	x		
Vermont			
Virginia			
Washington	x		wws2.wa.gov/dshs/onlinecso/cover.asp
West Virginia	x		www.wvdhhr.org
Wisconsin	x		
Wyoming			
TOTAL	30	6	7

SOURCE: Georgetown University Health Policy Institute
***** Indiana piloted a Web-based screening tool in three counties.
****** Rhode Island was in the process of developing a screening tool.

- Of the state Medicaid programs that developed screening tools, seven reported that the tools were available online.[9]
- States that had developed screening tools reported that the tools were also available through a number of other public programs, such as TANF, Aging Services, Disability Services, Food Stamps, or Housing Programs. Screening tools were also available through community-based organizations such as AARP, Area Agencies on Aging, and Legal Aid Offices.

[9] Applicants can also use a nationally available Internet-based tool, "Benefits CheckUp," developed by the National Council on the Aging. Benefits CheckUp can screen people for a large number of assistance programs, including the Medicaid and Medicare Savings Programs. The Benefits CheckUp tool can be found at http://www.benefitscheckup.org/. This survey did not ask whether the state informs potential applicants about Benefits CheckUp.

VI. RECERTIFICATION

Approaches to Simplifying the Recertification Process

Recertification, redetermination, renewal, re-enrollment, and eligibility review are all terms for the process of confirming that enrollees remain eligible for benefits. In some states, program participants are required to periodically reapply for benefits. In others, they only need to verify that their circumstances have not changed and, therefore, they remain eligible. The more the recertification process resembles an automatic re-enrollment, the more effective it is likely to be in retaining eligible participants (Remler and Glied, 2003). In a letter to state quality control directors, CMS noted that retaining eligible individuals and families in the Medicaid program has been a major problem, and redetermination procedures that decrease the likelihood of nonresponse may address this problem (Westmoreland, 2000c).

It is useful to examine aspects of the recertification process that could be simplified:

- Recertification forms;
- Frequency of recertification;
- Face-to-face interview requirements;
- Documentation requirements; and
- Notification and recertification processes.

Information Required on Recertification Forms

To ensure that Medicaid covers as many eligible people as possible, simplifying the recertification process may be as important as simplifying the initial enrollment process. Many of the issues related to forms that are considered during the initial application process are relevant to the recertification process, and many of the simplification strategies for recertification are similar to those used during the initial application process. For example, recertification forms can be shorter and simpler than the original application and still be effective. Program administrators can fill in parts of the form with information that is already known about the program participant (Ellwood, 1999; Nemore, 1999; Schulte, Pernice, and Rosenthal, 2000). With regard to Medicaid programs for children, 48 states allowed renewals by mail or telephone as of January 2002 (Cohen Ross and Cox, 2002).

Federal Requirements

Federal regulations require states to limit the information required during eligibility reviews for recertification to that necessary to determine ongoing eligibility or information related to circumstances that may change, such as income and residency (Periodic Redeterminations of Medicaid Eligibility Rule, 2001; Simplicity of Administration Rule, 1999; Westmoreland, 2000a). States cannot require beneficiaries to provide information that is not relevant to making an ongoing eligibility determination or that has already been provided and is not subject to change (Westmoreland, 2000a). Federal law does not require signatures on renewal forms (CMS, 2001a).

Findings: Recertification Forms

Results from the survey showed that a clear majority of states required less information for recertification than for original application**.** The survey results revealed the following state practices:

- A total of 30 states used different forms for the initial application and recertification for either full Medicaid benefits or the Medicare Savings Programs. Of those 30 states, 24 did so for both programs (Table 14).
- Eight of the 27 states that used different forms for the initial application and recertification for full Medicaid benefits had recertification forms that were four pages or shorter.
- Sixteen of 27 states that used the same form for initial application and recertification for Medicare Savings Programs had forms that were four pages or shorter.
- In other states, applicants had to complete lengthy forms at the time of the initial application and during recertification. For example, both the initial application and recertification forms for full Medicaid benefits were 23 pages in Maryland, 11 pages in Nebraska, 34 pages in Ohio, 28 pages in Rhode Island, 10 pages in Oregon, 12 pages in South Dakota, 15 pages in Vermont, 10 pages in Oklahoma, and 24 pages in West Virginia.

Frequency of Recertification

Frequent recertification requirements could burden beneficiaries, particularly if they are required to provide verification documents or appear for face-to-face interviews. Frequent reviews also increase the administrative burden on agency staff. A study of eligibility periods for the Medicaid program found that 12-month rather than 6-month eligibility periods substantially lowered administrative costs (Irvin, Peikes, Trenholm, and Khan, 2001). Another study found that recertification for children occurred annually in most states. Forty-two states, including the District of Columbia, determined Medicaid and SCHIP eligibility for children every 12 months. The remaining nine states required recertification at more frequent intervals (Cohen Ross and Cox, 2002).

Federal Requirements

Federal regulations require states to redetermine Medicaid eligibility at least once every 12 months, or whenever there is a change in circumstances that may have an impact on eligibility (Periodic Redeterminations Rule, 2001). When a state receives a report of a change in circumstances, it must conduct an eligibility review. No additional redetermination is required until a year from the date when the state reviewed the reported change, unless another change is reported (Westmoreland, 2000a).

Findings: Frequency of Recertification

The majority of state Medicaid agencies required annual recertification for either full Medicaid or the Medicare Savings Programs (Table 14). When more frequent recertification was required, the requirement tended to focus on full Medicaid rather than Medicare Savings Programs. Four states recertified beneficiaries for the full Medicaid program more than once every 12 months.

Table 14. Requirements for Full Medicaid and Medicare Savings Programs Recertification for the Elderly and Individuals with Disabilities, 2002

	Is a Different Form Used for Recertification?		How Often Is Recertification Required?		Is a Face-to-Face Interview Required?	
	Full Medicaid	Medicare Savings Programs	Full Medicaid	Medicare Savings Programs	Full Medicaid	Medicare Savings Programs
STATE	YES	YES	More often than annually		YES	YES
Alabama	x	x				
Alaska	x	x	x	x	x	x
Arizona						
Arkansas						
California	x	x				
Colorado	x	x				
Connecticut	x					
Delaware						
District of Columbia	x	x				
Florida					x	
Georgia	x	x				
Hawaii	x	x				
Idaho						
Illinois	x	x				
Indiana	x	x			x	
Iowa					x	x
Kansas						
Kentucky		x			x	
Louisiana	x	x				
Maine						
Maryland						
Massachusetts	x	x				
Michigan						
Minnesota	x	x				
Mississippi	x	x				
Missouri	x	x				
Montana	x	x				
Nebraska						
Nevada	x	x				
New Hampshire	x	x				
New Jersey		x				
New Mexico	--	--	--	--	--	--
New York	x	x			*	
North Carolina	x	x	x			
North Dakota	x	x				
Ohio					x	
Oklahoma						
Oregon						
Pennsylvania	x					
Rhode Island						
South Carolina	x					
South Dakota						
Tennessee						
Texas		x				
Utah	x	x				
Vermont						
Virginia	x	x				
Washington	x	x	x			
West Virginia			x		x	
Wisconsin						
Wyoming	x	x				
TOTAL	27	27	4	1	7	2

SOURCE: Georgetown University Health Policy Institute

***** New York reported that face-to-face interviews for recertification would not be required as of April 2003.

Only Alaska required recertification for Medicare Savings Programs more frequently than every 12 months. Alaska required recertification every six months for all program participants, including those seeking benefits from full Medicaid and Medicare Savings Programs. North Carolina and West Virginia required recertification every six months for those receiving full Medicaid benefits. Washington had 3-, 6-, and 12-month recertification periods, depending on the type of program.

Face-to-Face Interview Requirements

Face-to-face interview requirements present problems at recertification similar to those at the time of the initial application. Applicants with transportation and mobility limitations or scheduling conflicts related to employment face the same difficulties during the renewal process as during the initial applications process. These barriers reduce the likelihood that beneficiaries will complete the recertification process and continue to receive much-needed benefits.

Federal Requirements

Federal law does not require face-to-face interviews for recertification.

Findings: Face-to Face Interviews

Most states had eliminated the face-to-face interview requirement for recertification (Table 14). Seven states (Alaska, Florida, Indiana, Iowa, Kentucky, Ohio, and West Virginia) required a face-to-face interview to recertify for full Medicaid benefits. Two states (Alaska and Iowa) required a face-to-face interview to recertify for Medicare Savings Programs.

Documentation Requirements for Recertification

Income and asset documentation requirements pose the same barriers at the time of recertification as they do during the time of initial application. States should have some level of comfort in not requiring documentation during recertification, because the Medicaid agency already has information from the initial application and can verify current information through the IEVS and other sources.

Interviews with legal services workers, Older Americans Act program staff, social services agencies, and advocates from national organizations revealed that many applicants had their benefits terminated during the recertification period for failing to provide required documents within a certain time frame. Thus, applicants who initially met eligibility requirements but did not provide supporting documents in a timely manner were denied benefits for which they might have been eligible (National Senior Law Center, 1992).

Federal Requirements

Federal law does not require documentation to verify income or assets at renewal. As much as possible, states are required to conduct *ex parte* (one-sided) reviews of ongoing eligibility using information that is already available before contacting the beneficiary (Westmoreland, 2000a). Conducting *ex parte* reviews can simplify the redetermination process and avoid unnecessary documentation requests of beneficiaries.

Findings: Documentation Requirements for Recertification

The survey found that states were less likely to require verification documents during recertification than during the initial application process. The following are additional highlights from the survey (Table 15):

- Four states did not require beneficiaries to provide documents to verify income for recertification for full Medicaid benefits, and 11 states did not have this requirement for Medicare Savings Programs.
- With regard to assets, 7 states did not require beneficiaries to provide verification documents for full Medicaid benefits, and 16 states did not have this requirement for Medicare Savings Programs.
- Alabama used IEVS matches to conduct a system review for single individuals over age 65 who were enrolled in Medicaid or Medicare Savings Programs. Information about income was matched with SSA records. If there was no discrepancy, a notice was sent to the client stating that the review was complete for the year. If there was a discrepancy, a re-enrollment interview was necessary. Alabama instituted the policy as a cost-saving measure.
- In Maryland, an electronic database system that interacted with TANF**,** Food Stamp, and Medicaid programs automatically updated Medicaid when a change was reported to TANF and/or Food Stamp agencies. The next regular determination was rescheduled from the date of this *ex parte* review. This process allowed the state to collect necessary information without requiring the beneficiary to come in for an interview or to produce verification (CMS, 2001a).

Table 15. Documentation Requirements for Full Medicaid and Medicare Savings Programs Recertification for the Elderly and Individuals with Disabilities, 2002

	Are Documents Required to Verify Income?		Are Documents Required to Verify Assets?	
STATE	Full Medicaid	Medicare Savings Programs	Full Medicaid	Medicare Savings Programs
	NO	NO	NO	NO
Alabama				x
Alaska				
Arizona			x	x
Arkansas		x		x
California				
Colorado				
Connecticut		x		x
Delaware			x	x
District of Columbia				
Florida		x		x
Georgia		x		x
Hawaii				
Idaho				
Illinois		x		x
Indiana				
Iowa				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland				
Massachusetts				
Michigan				
Minnesota			x	x
Mississippi				x
Missouri				
Montana				
Nebraska				
Nevada	x		x	
New Hampshire				
New Jersey		x		
New Mexico	--	--	--	--
New York			*	x
North Carolina				
North Dakota				
Ohio				
Oklahoma				
Oregon				
Pennsylvania				
Rhode Island		x		x
South Carolina			x	x
South Dakota				
Tennessee				
Texas		x		x
Utah				
Vermont	x	x	x	x
Virginia				
Washington	x	x	x	x
West Virginia				
Wisconsin	x	x		
Wyoming				
TOTAL	4	11	7	16

SOURCE: Georgetown University Health Policy Institute

***** New York reported that documentation of assets for full Medicaid would not be required as of April 1, 2003.

Recertification Notification Process

People are more likely to remain enrolled in programs if they are aware that they must periodically recertify for benefits, if they understand the recertification process, and if the process is simple. Beneficiaries have reported that they lost their benefits because they were not aware of the need to reenroll, or in some instances, the notification arrived too late in the mail. QMB and SLMB beneficiaries sometimes discover that they are no longer enrolled in the programs when the Medicare Part B premium is deducted from their Social Security check because the Medicaid program is no longer paying the premium (Walsh and Hoover, 2001). States may design their own notification and recertification processes. Some states routinely generate forms to tell beneficiaries that they must be recertified to continue receiving benefits, thereby leaving it up to the beneficiary to reapply for benefits. Others use techniques that do not require as much effort on the part of the beneficiary. For example, in addition to notices, they send applications for recertification. The process is easier in states that include existing information on the renewal form and request only changes in the information (Westmoreland, 2000c). Beneficiaries receive notices that ask them to verify that their income or resources have not changed. They are informed that their enrollment will continue unless they inform the Medicaid office that they no longer are eligible for benefits. When they sign and return the notices, they are re-enrolled in the program. This is known as *passive* recertification.

Federal Requirements

There are no specific federal requirements regarding the recertification process.

Findings: Recertification Notification Process

Survey responses indicate that many states used simplified notice and recertification processes. The survey revealed the following practices (Table 16):

- All responding states notified beneficiaries that they had to recertify as a condition of continued Medicaid coverage. The majority of states reported that they sent notices one or two months in advance of the date of recertification. Since the notification often occurred locally, there might be some variation within a state. In New York, for example, beneficiaries were notified anywhere from one to three months before the date of recertification, depending on the district where they lived.
- Ohio was the only state that reported having no policy regarding time frames for notification of the need for recertification.
- Recertification procedures varied. All states provided program participants with some type of notification that they had to reapply for benefits. Many states also sent an application or a renewal form to complete. Beneficiaries in a small number of states received a partially completed application and were asked to complete and sign the form to verify that they were still eligible for benefits.
- Five states—North Dakota, Oklahoma, Rhode Island, Tennessee, and Texas—used a passive recertification approach for full Medicaid. Four states—North Dakota, Oklahoma, Tennessee, and Texas—did so for Medicare Savings Programs.
- Recertification processes may differ for people who have been Medicaid beneficiaries for some time. In Texas, for example, full Medicaid beneficiaries received an application to

complete for their first annual review. If the case was determined to be stable—that is, there was no change in income at the first review—beneficiaries received a short review letter for the second annual review and later reviews. Texas uses a short review letter for all recertifications for Medicare Savings Programs.

Table 16. Recertification Notification Procedures for Full Medicaid and Medicare Savings Programs for the Elderly and Individuals with Disabilities, 2002

Notification Procedure	Number of States	
	For Full Medicaid Coverage	For Medicare Savings Programs
Beneficiaries receive a notice that they must reapply	36	35
Beneficiaries receive an application or a renewal form to complete	33	34
Beneficiaries receive a partially completed application and are asked to sign the form to verify that they still are eligible	10	10
Beneficiaries are notified that their benefits will continue unless they inform officials that their circumstances have changed	5	4

SOURCE: Georgetown University Health Policy Institute

VII. CONCLUSION

The enrollment process for the elderly and individuals with disabilities in the full Medicaid program and the Medicare Savings Programs was simpler in many states in fall 2002 than just a few years earlier. Despite such progress, opportunities to simplify enrollment for this population still exist. Some policy changes, such as eliminating face-to-face interview requirements and providing translated written materials, had been adopted by many, but not all states. Other changes had not been widely adopted. For example, only a few states had eliminated documentation requirements or significantly simplified the recertification process. Efforts in certain states show that change is feasible and demonstrate how elements of the enrollment process can be designed to conform to, but not exceed, federal requirements. Enrollment simplification has advantages for applicants but may also be advantageous for states when administrative costs are reduced.

As states face the challenge of assisting with enrollment for the new Medicare Part D low-income subsidy, and as they consider the substantial overlaps in the populations eligible for both Medicaid benefits and the low-income subsidy, simplifying the enrollment process for Medicaid and the Medicare Savings Programs may become more attractive.

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APPENDIX

Survey of the Medicaid Enrollment Process for the Elderly and Disabled
AARP Public Policy Institute and Georgetown University, Center on an Aging Society

State:_____ Email address:_____

Name:_____ Phone number:_____

Title:_____ Fax number:_____

If you would prefer to complete this survey electronically, please go to
http://ihcrp.georgetown.edu/agingsociety/survey.html

APPLICATION FORMS FOR THE ELDERLY AND DISABLED

1. Is the same application form used for all types of Medicaid coverage, including full coverage and coverage for the Medicare Savings Programs (QMB, SLMB, and QI)? ☐ Yes ☐ No
   If yes, how many pages is the application? _____
   If no, how many pages is the application:
   For full Medicaid coverage_____ For the Medicare Savings Programs_____

2. Are Medicaid applications for the elderly and disabled used for non-Medicaid programs as well? ☐ Yes ☐ No
   If yes, which programs? _____

3. Are applications for the elderly and disabled printed in languages other than English?
   For full Medicaid coverage: ☐ Yes ☐ No If yes, what other languages? _____
   For Medicare Savings Programs: ☐ Yes ☐ No If yes, what other languages? _____

4. Have the applications for the elderly and disabled been designed to accommodate applicants with low literacy levels?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No

DOCUMENTATION REQUIREMENTS FOR THE ELDERLY AND DISABLED

5. Are elderly and disabled applicants required to provide documents to verify income?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No

6. Are elderly and disabled applicants required to provide documents to verify assets (resources other than income)?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No

7. Does Medicaid use data from other public programs (such as pharmacy assistance programs), state agencies (such as the Department of Finance or Revenue), or federal agencies to verify income or asset information?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No
   If yes, which programs and/or agencies?_____

THE APPLICATION PROCESS FOR THE ELDERLY AND DISABLED

8. Is there a separate staff that reviews applications for Medicare Savings Programs? ☐ Yes ☐ No

9. Approximately how long after they apply are applicants informed of whether they are eligible for benefits?
   For full Medicaid coverage: _____
   For Medicare Savings Programs: _____

10. Are face-to-face interviews required as part of the application process?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No

11. Does the Medicaid office provide:
   Transportation vouchers for applicants? ☐ Yes ☐ No
   Extended (evening and weekend) office hours? ☐ Yes ☐ No

12. In which of the following ways can applications be submitted? (Check all that apply)

	Full Medicaid coverage	Medicare Savings Programs
In person	☐ Yes ☐ No	☐ Yes ☐ No
By mail	☐ Yes ☐ No	☐ Yes ☐ No
By fax	☐ Yes ☐ No	☐ Yes ☐ No
By phone	☐ Yes ☐ No	☐ Yes ☐ No
On-line	☐ Yes ☐ No	☐ Yes ☐ No

13. Please estimate the percentage of applications submitted within the last six months using each method:

	Full Medicaid coverage	Medicare Savings Programs
In person	_____%	_____%
By mail	_____%	_____%
By fax	_____%	_____%
By phone	_____%	_____%
On-line	_____%	_____%
TOTAL	100 %	100 %

IDENTIFYING AND ASSISTING ELDERLY AND DISABLED APPLICANTS

14. Does Medicaid "outstation" eligibility staff for the elderly/disabled? That is, do Medicaid staff work at locations other than the Medicaid office to help enroll elderly/disabled applicants?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No
   If yes, how many “outstation” locations are there in the state? _____
   If yes, what percentage of applications for the elderly/disabled come from outstationed locations? _____
   If yes, what types of locations have “outstationed” workers?
   _____

15. Does Medicaid "deputize" people to assist the elderly/disabled with the application process? That is, does Medicaid provide some training for people outside the Medicaid program and then give them the authority to help with some aspects of the enrollment process?
   For full Medicaid coverage: ☐ Yes ☐ No
   For Medicare Savings Programs: ☐ Yes ☐ No
   If yes, what functions do those who are deputized perform? (Check all that apply)
   ☐ Helps complete applications
   ☐ Conducts face-to-face interviews
   ☐ Accepts applications
   ☐ Helps process applications
   ☐ Other _____

16. Has your state's Medicaid program developed screening tools that potential applicants can use to determine whether they may be eligible for benefits? ☐ Yes ☐ No
17. If yes, where are the tools available? (Check all that apply)
    - ☐ Other public programs including _____
    - ☐ Community-based organizations, including _____
    - ☐ On-line at _____
    - ☐ Other_____

18. Does your state's Medicaid program make available screening tools developed by others?
    ☐ Yes ☐ No
    If yes, what tools are used? _____

RECERTIFICATION FOR THE ELDERLY AND DISABLED

19. Is the recertification form the same as the initial application?
    For full Medicaid coverage: ☐ Yes ☐ No
    For Medicare Savings Programs: ☐ Yes ☐ No

20. How often is recertification required?
    For full Medicaid coverage: _____
    For Medicare Savings Programs: _____

21. Is a face-to-face interview required for recertification?
    For full Medicaid coverage: ☐ Yes ☐ No
    For Medicare Savings Programs: ☐ Yes ☐ No

22. Are beneficiaries required to provide documents to verify income for recertification?
    For full Medicaid coverage: ☐ Yes ☐ No
    For Medicare Savings Programs: ☐ Yes ☐ No

23. Are beneficiaries required to provide documents to verify assets for recertification?
    For full Medicaid coverage: ☐ Yes ☐ No
    For Medicare Savings Programs: ☐ Yes ☐ No

24. Are beneficiaries notified that they must be recertified?
    ☐ Yes ☐ No
    If yes, how far in advance of the date of recertification are beneficiaries notified? _____

25. What is the procedure at the time of recertification? (Check all that apply)

	Full Medicaid coverage	Medicare Savings Programs
▪ Beneficiaries receive a notice that they must re-apply	☐	☐
▪ Beneficiaries receive an application to complete	☐	☐
▪ Beneficiaries receive a partially completed application and are asked to sign the form to verify that they still are eligible	☐	☐
▪ Beneficiaries are notified that their benefits will continue unless they inform officials that their circumstances have changed	☐	☐
▪ Other_____	☐	☐

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26. When did you first make changes to ease the enrollment process for the Medicare Savings Programs?

_____