FACILITATING ACCESS TO MEDICAID

By
Rebecca L. Mushkin

A dissertation submitted to the
Graduate Faculty in Social Welfare in
Partial fulfillment of the requirements for
the degree of Doctor of Social Welfare,
The City University of New York

1995

This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

9/5/95
Date

Chair of Examining Committee

9/5/95
Date

Executive Officer

Charlotte Muller

Mimi Abramovitz

Supervisory Committee

THE CITY UNIVERSITY OF NEW YORK

Abstract

Facilitating Access to Medicaid

by

Rebecca Mushkin

Advisor: Professor Irwin Epstein

This research study was conducted to determine the facilitators for and the obstacles to accessing Medicaid for older people. Particular attention was given to the experiences of older women applicants. A sample of 102 social worker, elder care attorneys and other client advocates was obtained over a 6 month period of time. Advocate questionnaires were purposefully distributed to individuals who were involved in assisting older persons to obtain Medicaid. A small sample of eight female clients were interviewed to obtain their perspectives on the difficulties they encountered during the Medicaid application process. Advocates indicated a number of client and organizationally-based obstacles to accessing coverage for the Medicaid eligible elderly. In addition, they suggested a variety of access strategies developed by elder care advocates to help them more efficiently access Medicaid coverage for their clients. Recommendations for policy, training, and practice are included.

ACKNOWLEDGMENTS

To Silvano Peselli

I would like to dedicate this dissertation to my husband, Silvano, who gave me all of the important things in life, which allowed me complete this work.

There are a number of other individuals who each in their own way helped me to accomplish my goal of completing my doctorate:

I would like to express my sincere appreciation to Dr. Irwin Epstein, the Chair of my dissertation committee. Professor Epstein was my advisor throughout most of the doctoral program, giving me continuous guidance and support over the better part of the last six years. I would also like to acknowledge the contributions of Dr. Charlotte Muller and Dr. Mimi Abramovitz, who served as members of my committee. Their knowledge of health care coverage and women was especially valuable to this study.

I would also like to express my appreciation to the one hundred thirty four social service advocates who took the time from their hectic schedules to answer my questionnaires. This project could not have been accomplished without their help. My appreciation is also extended to the staff and clients of Lenox Hill Neighborhood House for their help and participation in this study.

On a more personal note, my gratitude is extended to Dr. Michael Stern for his support and encouragement--for giving me my first push forward--to Dr. Barbara Dramin and Dr. Audrey Weiner, who helped keep me going, and never gave up on me.

Table of Contents

Abstract....iv

Acknowledgments....v

Chapter 1 Introduction and Review of the Literature....1

Chapter 2 Historical Context of Medicare and Medicaid....23

Chapter 3 Methodology: Research Design and Plan for Implementation....50

Chapter 4 Findings: Advocate Responses....81

Chapter 5 Findings: High Volume Advocates....106

Chapter 6 Strategies Recommended by Advocates....126

Chapter 7 Findings: Client Responses....150

Chapter 8 Conclusion: Recommendations for Training, Practice, and Policy....179

Appendices

Appendix 1 Research Instruments....203

Appendix 2 Outreach Materials....241

Appendix 3 Medicaid Materials....247

Bibliography....252

List of Tables

Table 1 Profile of Advocate Respondents....76

Table 2 Time Frame of Client and Community Outreach....78

Table 3 Response Rates of Outreach Efforts....79

Table 4 Difficulties Accessing Medicaid Coverage....83

Table 5 Mean Time Distributions for Medicaid and Medicaid Funded Home Care....84

Table 6 Percent Distributions for Obtaining Medicaid and Medicaid Funded Home Care....85

Table 7 Percent Distributions of Respondents' Time Spent Assisting Applicants....86

Table 8 Respondents' Time Spent Assisting Applicants....87

Table 9 Rank Order of Reasons Eligible Women Do Not Apply for Medicaid....90

Table 10 Obstacles Encountered by All Respondents During the Application Process....91

Table 11 Respondents' Descriptions of Assistance Received from CASA....99

Table 12 Profile of HighVolume Respondents....108

Table 13 Comparison of High and Low Volume Respondents' Time Duration for Medicaid....109

Table 14 Comparison of High and Low Volume Respondents: Percentage of Occurrence Of Specific Difficulties....112

Chapter One

Introduction and Review of the Literature

There has been a dramatic increase in the proportion of elderly persons over the past twenty years. Currently over 12% of the population are 65 years of age and older (U.S. Bureau of the Census, 1994). The fastest growing segment of the population consists of people 85 years of age and older. According to demographic projections, the number of elderly will continue to increase after the turn of the century. It is estimated that by the year 2030 older people will represent 22% of our total population (Oktay & Palley, 1991).

The health care needs of the elderly are different from those of the rest of the population. In general, physical illness and vulnerability usually increase with age. The loss of income, social roles, family, friends, and often the abilities for self care also impact upon an older person's life and level of independence. Now that older people are living longer, they usually are doing so while experiencing physical impairments and chronic illnesses (Estes, Gerard, & Clarke, 1984). Medical and medically related services are vital to maintaining the safety and well being of the aged. The accessibility and financing of long term care are

issues which have been documented in the literature (Brown, 1984; Crystal, 1990; Estes, 1989). It is anticipated that as the elderly population continues to expand, coverage and accessability for health and long term care will increase in importance.

Older women are in greater need of health and long term care than older men. Women outnumber men within each age cohort of the elderly population. They represent seven out of every ten of those over 85 years of age (Estes, et al. 1984). Women are vulnerable to the high cost of living, especially the expenses for medical care and long term care. Socially and economically women are at greater risk than men (Sidel, 1986). Because the problems of old age are primarily the problems of older women, this doctoral dissertation will focus, in part, upon the difficulties advocates of older people, encounter accessing Medicaid coverage. The goal of this doctoral research project is to describe and define the specific obstacles to Medicaid, placing emphasis upon identifying those factors which help facilitate access to coverage. A projected outcome of this study will be to establish practice recommendations to help advocates more effectively access coverage for their clients.

The graying of America will place increased demands upon our already strained health care system. Older people will continue to need accessible, affordable, and adequate medical care and services. As our nation continues to grapple with the lack of a national health care policy, the health care needs of the elderly illustrate many of the problems inherent in our current health care system. Although the majority of elderly are eligible for

and receive Medicare coverage, there are significant gaps in their health care coverage. For example, Medicare usually pays for most acute, but not for all chronic care needs. Medicare will pay for physician and laboratory fees, but not for the ongoing personal care needs of most impaired elderly. As most older people eventually suffer from chronic physical problems, they find themselves uncovered for their long term care needs. While Medicare can provide limited home health care following an acute medical illness, it does not provide coverage for the chronic ongoing care many older people need.

The Medicare program, enacted in 1965, did not turn out to be the panacea of health insurance it was originally intended to be. Medicare was enacted to provide comprehensive medical coverage for the aged (Brown, 1984); however, restrictions in its coverage leave many elderly uncovered for their health care needs. Lack of coverage for long term care creates a "no-care zone" (Estes, et al. 1984), commonly referred to as the Medicare gap. Elderly individuals who are unable to purchase private supplemental health insurance are left paying out of pocket for medical charges not covered by Medicare. Medicare alone is insufficient to cover many of the medical needs of older people. Prescription drugs, home health care, durable medical equipment, and care in a skilled nursing facility are not covered fully or at all under Medicare.

The Medicaid program, which was enacted with Medicare in 1965, was designed to provide access to medical care for the poor. Because of its coverage for chronic care, Medicaid has become a viable alternative for the financing of long term care for poor older

people. Although Medicaid offers coverage for acute and chronic medical care, less than 40% of those who are eligible for Medicaid are enrolled (Chang & Holahan, 1990). Obstacles to obtaining access to Medicaid explain why the majority of the nation's poor do not have coverage. Strict restrictions on eligibility have prevented many eligible individuals from gaining access to Medicaid (Brown, 1984). Lack of public awareness about eligibility and coverage (Alexander & Podair, 1969; Grau, 1987; Quadagno, Meyer & Turner, 1991), fear of an economic stigma (Alexander & Podair, 1969; Estes, et al. 1984), and administrative hurdles are all obstacles to obtaining access to the Medicaid program.

Women usually outlive their spouses, often depleting their savings while providing care for their husbands. After the loss of their spouses, many older women find themselves socially isolated and economically strained. They are often at financial risk. Following the death of a spouse there is usually less income from Social Security and from investments, especially if these were used to pay for medical care. For single or divorced older women, pensions and Social Security benefits are often modest, reflecting the financial conditions of women working in a dual labor market (Stone & Minkler, 1984). Children, if any, often live at a distance and have their own families and responsibilities. Single older women may be without the support of an extended family. When the older woman becomes physically impaired there may be no one to care for her. Often these are the women who are referred to a social service agency like Project SCOPE of the Lenox Hill Neighborhood House, the site for this study. Project SCOPE is a case management program, funded by the New

York City Department for the Aging, to provide care coordination services for frail older adults. Project SCOPE is sponsored by the Lenox Hill Neighborhood House, a one hundred year old community-based settlement house. Over the past 100 years, the organization has provided a variety of services for those who live, work, or go to school in its geographic community (from 59th to 96th Streets, east of Fifth Avenue, in New York City). In addition to Lenox Hill Neighborhood House, staffs at numerous hospitals and social service organizations throughout the New York metropolitan area were invited to participate in this study.

Review of the Literature

Review of the aging and health care literature indicates that the obstacles to and facilitators of Medicaid access for older people are an area which has not been sufficiently studied. This literature review was approached by investigation of related topics. This discussion will be broken down into several topic areas: poverty and the elderly, poverty and older women; financing long term care; health care access and utilization; historical context of Medicare and Medicaid; Medicaid coverage, policies and utilization, and obstacles to Medicaid access. The literature discussion on poverty and older people, and older women in particular, reveals an economic condition in which older people, especially older women, are eligible for and in need of Medicaid-funded services. The literature reviews on Medicare and Medicaid identifies health care policy issues, indicating the need for greater health care access for the elderly.

Poverty in Old Age

Poverty can be defined in a number of ways. The Federal government defines poverty among the aged according to guidelines established by the Social Security Administration and the Bureau of Labor Statistics (Girshick & Williamson, 1982). Originally, the poverty threshold was calculated according to the minimal amount of money needed to meet basic nutritional standards prescribed by the Department of Agriculture (Girshick & Williamson, 1982). Over the past 30 years the percentage of elderly who are impoverished has declined (Estes, 1989), to a large extent the result of the Supplemental Security Income, Social Security, Medicare, Medicaid, and other entitlement programs targeted to low-income elderly. Grau (1987) states that today's elderly are better off economically than those of previous generations, yet there are still significant numbers of poor elderly, especially women and minorities (Estes, 1989). Presently 12.2% of the elderly population lives below the poverty line (Bureau of the Census, 1994). All together 19.7% of the elderly are estimated to be poor or near poor (Bureau of the Census, 1994). Almost 73.2% of the poor elderly are female (Bureau of the Census, 1994). Women and minorities are considered the most economically disadvantaged (Estes, et al. 1984). For example, in 1992 the average monthly Social Security check for a man was $740, for a woman it was only $551 (Social Security Bulletin, 1993). To a large extent these differences directly reflect the differences in salary rates and employment records between men and women, and between whites and blacks.

One of the most crucial problems facing all elderly is lack of sufficient income. Following retirement, income usually declines by approximately 50% (Estes, et al. 1984). Poverty in the elderly usually results from living on a fixed income, while the costs of living continue to increase with inflation (Grau, 1987). The high costs of health care not covered by Medicare usually consume a substantial portion of the older person's limited income. It is a common misconception that Medicare and Social Security cover the needs of the retired elderly. On average, Medicare covers only 47.5% of the cost of hospital care needed by the elderly (Statistical Abstracts, 1992). According to Gornick et al. (1985) out of pocket medical expenses for the poor aged represent more than 10% of their income. It has been estimated that older women spend 28% of their median income on health care costs (Older Women's League, 1992). In the 1990's the elderly will spend close to 19% of their income on health care expenditures (Select Committee on Aging, 1985). Such expenses are devastating for elderly of low and middle income groups (Estes & Binney, 1988; U.S. House Select Committee on Aging, 1985).

According to the Commission on Elderly People Living Along (Commonwealth Fund, 1987), individuals who are 85 years of age and older, minority elderly, and those who live alone are most at risk for falling through the gaps of health care coverage. They do not have the financial resources to pay for health care, yet they are not poor enough to qualify for entitlement programs for the poor including Medicaid (Grau, 1987). These individuals are usually at financial risk. Either their health or their nutrition will be compromised in order to meet their monthly expenses on a limited income (Muller, 1988). Estes (1989)

defined the concept of the "no care zone" to describe the condition of many elderly who fall through the cracks. Elderly in the "no care zone" need health care and other community-based services but they have no way to pay for them. As a result, this group of elderly usually goes without needed care. According to Grau (1987), those at greater risk of "illness-engendered poverty" are those who suffer from chronic illnesses, are of moderate to low income, and lack the availability of assistance from friends, family and neighbors. Those whose incomes fall into the lower to middle range and who are without supplemental Medigap coverage are most likely to become impoverished while in the process of paying for medical expenses that are not covered by Medicare (Grau, 1987).

Dutton (1986) and Luft (1978) demonstrated a strong relationship between health and socioeconomic status, as measured by disability, chronic illness and longevity. They found that elderly with low incomes were more likely to experience poor health than those of higher income (Estes, 1989). Grau (1987) also found that socioeconomic status had an influence upon health status. Individuals who became impoverished in old age were more likely to suffer from chronic illness than non poor elderly, and this is especially true for women and minorities. Health problems may also lead to changes in economic conditions for the elderly. Chronic illness even for the middle and upper middle class can lead to impoverishment. As the condition of poverty is necessary before one can qualify for publicly funded assistance, policies like Medicaid's require that assets be spent down in order to qualify for assistance (Grau, 1987).

Poverty and Older Women

While the problems affecting the poor elderly affect both men and women, these problems are more pronounced for women. Zones, Estes & Binney (1987) state that aging is primarily a woman's issue because women live longer and outnumber men by two-thirds among the oldest old. According to Dr. Robert Butler, the "problems of old age in America are largely the problems of women," (NIA, 1979). Gender differences in health, longevity, social roles and finances impact upon the older woman, placing her in an especially vulnerable position during old age. As women tend to live longer, they are more likely to live with chronic illness and disease (Grau, 1984). Many of the problems of older women are related to the low salaries they received for their work. On average, women receive 60% of men's earnings for similar work.

Many women approach retirement without adequate financial resources, especially if they are widowed and living alone. These women are especially vulnerable to poverty in old age (Warlick, 1983). According to Lewis & Butler (1984), being an older woman usually means living alone on a low or poverty-level income, often living in substandard housing without adequate medical care. According to Grau (1987) one-fifth of older women live in poverty. Single never-married women are even more likely to be impoverished in old age (Grau, 1987). Minkler & Stone (1985) estimate that almost 90% of elderly poor women are single. Older women have been discriminated against all their lives, and as a result are often poverty stricken and socially isolated (Lewis & Butler, 1984).

Social Security, which was established to safeguard the aged after retirement, discriminates against older women (Lewis & Butler, 1984). Women earn less than men and as a result they receive lower Social Security incomes. Because many women who do not work for wages are unpaid for work inside the home, they receive little or no Social Security benefits on their own earnings record. If married, they qualify for benefits as a dependent spouse. As Social Security is based upon regressive taxes, working women pay more tax proportionately than men because of their lower incomes (Lewis & Butler, 1984). Although Social Security was intended to protect the aged from poverty, it exaggerates the financial differences between men and women because its benefits are differential according to wages received and marital status, favoring married couples over all other categories (Warlick, 1983). As a result of the differences in the benefits of one and two earner couples, the surviving spouse of a two-wage earner couple will generally receive less Social Security than the surviving spouse of a one-earner couple with the same income (Estes, et al. 1984).

For many older women, Social Security is their only source of income. Social Security makes up 50% or more of the total monthly income for 73% of non-married women, and for 34% of these women it makes up 90% or more (Muller, 1983). On average, women's Social Security benefits are one-quarter less than men's (Social Security Bulletin, 1993). Pension income, which often supplements Social Security, is received by only 20% of older women as compared to 43% of men (Grau, 1987). Until a Supreme Court decision in 1983, it was legal for pension plans to pay female retirees at lower rates because of their

anticipated greater longevity (Estes, et al. 1984). According to Estes, et al. (1984) "the root of the income problem for women stems from the labor market, wherein differential pay, low wage occupations, and episodic work participation due to familial commitments have a combined and often devastating effect in later years."

Some women do not become poor until old age. Lewis & Butler (1984), have described this segment of older women as the "newly poor." These are women who, without regular income, assets, or the financial assistance of a spouse, become impoverished. As they spend down their assets in order to become eligible for Medicaid and other entitlement programs, these women become the "newly poor," people who have lived most of their lives as part of the middle class, but who suddenly find themselves among the poor or near poor (Sidel, 1986). Although older men are also afflicted with poverty, there are more profound and greater consequences for women than for men. Women are at a greater risk of impoverishment in old age. Widowhood and/or chronic illness makes women especially vulnerable to poverty (Grau, 1987). There is a gender gap between men and women throughout the life span. There are more male babies born than female, but females begin to outnumber males by age 18. By age 65 there are 146 females for every 100 males. These ratios continue to increase throughout the remainder of the life cycle (Lewis & Butler, 1984). In 1989, women could be expected to live to be 78.6, while men could be expected to reach age 71.8 (NCHS, 1989). Women who reach the age of 65 can expect to live to be 83.8 years old (NCHS, 1989).

Older women are the fastest growing segment of the US population (Estes, et al. 1984). Women live longer than men, but they often experience chronic disabilities during old age. In addition, women tend to be care givers to others, especially their husbands, often neglecting their own health care needs while caring for others. Women are the primary providers of informal long-term care, providing 80% of the nation's care (Arendell & Estes, 1987). Serious problems are anticipated because of our nation's reliance on this informal care based upon women's work in the family. It is anticipated that there will soon be a shortage of care givers for the elderly (Soldo & Manton, 1985).

Financing Long Term Care

Most older people generally seek out the assistance of their family, friends, and neighbors when they need help. According to Liu, Doty & Soldo (1990), 80% of older people receiving care receive it only from informal care givers. It is only when these informal supports are unable to provide the assistance they need that they turn to formal social services for help. At this point most aged confront the issue of how to pay for long term care (Grau, 1987). There are very few private health insurance policies that cover long term care. Thus, most long term care is paid for out of pocket by the aged (Harrington, Estes, Lee & Newcomer, 1986). Although Medicare was enacted to provide affordable medical care coverage for the elderly, the elderly are now spending more of their income on health care costs than they did before Medicare was implemented (Crystal, 1990). Feder, Moon & Scanlon (1987) found that the elderly were spending almost 12% of their

income on medical expenses not covered by Medicare, and 10% were paying as much as 20%.

Many older women are not able to afford needed health care services, yet they are not poor enough to qualify for Medicaid. These women, caught in the "no-care zone", manage through the assistance of friends, neighbors, and relatives (Sidel, 1986). According to Sidel (1986), society's reluctance to provide low cost preventive health care results in more costly long term care later on. According to Estes, et al. (1984) policy related issues of concern to older women include the need to provide health care access for those who are living on low to moderate incomes. Estes, et al. (1984) describe our health care system as an inadequate and fragmented system geared toward institutional services. This system provides few community alternatives, often leaving the burden of care upon the family and frequently upon the informal care giving of older women.

Aging Policy and Long Term Care

According to Estes (1989), there have been seven major turning points in aging policy over the past century. The first was the Social Security Act (SSA) of 1935. This act set up the structure for old age assistance, unemployment and social services. The SSA formally recognized the need for minimal financial security for the aged.

The second major turning point in aging policy was the defeat of National Health

Insurance in 1940. And the third was the enactment of Medicare and Medicaid in 1965. Enacted during the Presidency of Lyndon B. Johnson, Medicare and Medicaid were established to address the problems of health care access for the elderly and the poor. A more detailed discussion of Medicare and Medicaid will be provided in subsequent sections of this literature review. Supplemental Security Income (SSI) was enacted in 1972, and implemented in 1974 to provide income assistance for the blind, disabled, and poor elderly. SSI represented a federal and state partnership, providing cash assistance for the most vulnerable members of society. Most elderly recipients of SSI are very old and very poor women (Estes, 1989).

Enactment of Title XX of the SSA was the fourth major turning point in aging policy. Title XX, enacted in 1974, provides block grants to the states for social services for recipients of Aid to Families with Dependent Children (AFDC), SSI, and Medicaid. Improvements in SSA payments reflecting the cost of living indexing constituted the fifth turning point in aging policy. These increases contributed to the most significant decline in poverty of the aged over the last 20 years. In the 1980's Reagan's New Federalism created a policy revolution. California's proposition 13 in 1978, the 1982 Omnibus Budget Reconciliation Act (OBRA), and the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA) all halted the growth of state and local revenues. Most states and the federal government began using austerity policies to contain costs. In the late 1980's the use of diagnosis related groups (DRG's) to contain hospital costs also had a significant impact upon both medical costs and care provision for the aged (Estes, 1989).

As illustrated above, social welfare policies have evolved from providing financial protection for the aged to cost containment policies like DRG's (Kutza, 1981). Currently, social welfare policies discourage family and community-based support. For example, family care givers who provide the majority of care to the frail elderly are not supported in their efforts to keep the elderly at home. According to Estes, et al. (1984) current tax structures do not provide incentives like tax deductions to family members who provide financial assistance to their elderly relatives. Other policies such as Medicaid's "spend down" process require the aged to impoverish themselves before they are eligible to apply for assistance. Severe limitations in Medicare's home health care policies leave many elderly, who are unable to care for themselves at home, to seek more expensive residential care.

The health care literature suggests that an estimated 14% of our population have no health care coverage at all (Statistical Abstracts, 1992), while 20% of those with coverage are underinsured (Sulvetta & Swartz, 1986). The United States and the Republic of South Africa are the only two developed countries that are without long term care for the aged. Lack of a long term care policy for the aged is part of a larger problem--the lack of a national health care system. Until this is resolved older people will have no alternative than to purchase costly and limited private long term care insurance or supplemental Medigap coverage. For those who are unable to purchase private insurance coverage there are gaps in their health care coverage. Long term care costs and the uninsured costs of an acute illness raise the potential for economic disaster for low and middle income elderly

(Crystal, 1990).

The problem of paying for long term care is one which affects most of the elderly population. Even the very wealthy have the potential of becoming impoverished after paying for long term care. Branch, Friedman, Cohen, Smith & Socholitzky (1988) estimate 47% of elderly would become impoverished within one year paying for the home care costs for an Alzheimer's victim. Likewise the risk of impoverishment is very high if an older person should need home care or nursing home care on an ongoing basis. Branch, et al. (1988) found that 46% of those over 75 years of age would become impoverished after only 13 weeks of nursing home care. In another study, Harris (1988) found that 82% of Americans could not afford to pay for long term care either in the home or in a nursing home. The American Association for Retired Persons (AARP, 1987) found that almost 50% of those interviewed did not know whether Medicare or other insurance would cover the costs of a long term nursing home stay. Forty-five percent felt that paying for long term care would become a major concern for them as they aged.

To address the gaps in coverage for long term care, gerontologists including Branch et al., 1988 have recommended the implementation of a universal insurance program which covers long term care (Branch, et al. 1988). Coverage for long term care would ensure that regardless of financial circumstances all elderly needing extensive long term care would not become impoverished. Eighty percent of those interviewed by Harris (1988) were in support of Federally sponsored long term care insurance for the aged and

chronically impaired. Brown (1984) recommended that a national health insurance program be progressively financed, uniform in coverage, its costs contained within a fixed yearly budget, and administered publicly at Federal, State, and local levels. Unfortunately recent attempts by the Clinton administration to implement a national health care policy were unsuccessful, despite the strong political force of the aged. Although 90% of elderly are registered voters, according to Lewis & Butler (1984), fewer actually vote. Medicare and Medicaid have historically reduced the political demand for national health coverage and the need for long term care coverage (Brown, 1984).

Many older persons who are not able to afford private long term care insurance apply for Medicaid. Their care is then financed through general tax revenues rather than through the social insurance system (Muller, 1988). Medicaid is a major source of third party coverage for long term care (State Controller's Office, 1989). According to Liu, et al. (1990), turning to Medicaid is more common among elderly living in the community than for those in nursing homes. Some elderly are essentially forced to spend down their assets before they are eligible for Medicaid's publicly funded assistance (Liu, et al. 1990).

Health Care Access and Utilization

Health Care Access

The American health care system has been revered as the finest in the world, yet a

growing proportion of people are denied access to this system. According to Crystal (1990), the American health care system has socialized the financing of care while privatizing the delivery of care. In order for people to obtain care, health care must be accessible, affordable, and cost containable (Estes, 1989). According to Wan (1982) access to health care is a complex process. Health care is not obtained simply by the existence of health services. Rather there are four major factors which determine access: availability, affordability, accessibility and acceptability (Petchers & Milligan, 1988). For many people, especially the aged, affordability is a major barrier to health care access. Aday & Anderson (1984) and Cantor & Mayer (1976) found that lack of sufficient finances was the major reason that older people did not seek medical care when necessary. Affordability is also the major barrier to health care for the minority aged (Petchers & Milligan, 1988). For some older people, lack of transportation or escort to medical services, forms another barrier to access (Petchers & Milligan, 1988). Lack of case management services, which help older people negotiate the various barriers to health care services, is another obstacle to access to health care services (Monk, 1990).

Health Care Utilization

In addition to health care access, heath care utilization is also of importance to the health and well being of the aged. A number of variables have been found to influence utilization of health care services. Andersen & Newman (1968) developed a framework for

understanding health care service utilization. According to their framework three categories of determinants were found to influence health service utilization: predisposing factors, enabling factors, and need factors. A brief description of this model will be presented. Predisposing factors include individual preexisting characteristics of the individual which may affect service needs and/or utilization. Preexisting characteristics may include demographic factors like age, gender, ethnicity, and marital status--and such factors as family size, education, occupation, history of past illness, and health attitudes and beliefs. Enabling factors represent those qualities that either facilitate or create barriers to the use of service, such as place of residence, financial resources, knowledge of services, and the ability to find and travel to services. Need factors include subjective and objective determinants of the need for health care, that is, number of health conditions, and perceived health conditions (Strain, 1991).

Predisposing characteristics have an influence upon the use of health care services by the aged. Gender is one indicator which can influence use of services. Males are more likely to be hospitalized than women (Strain, 1991), while women are more likely to be institutionalized for long term care (Butler & Newachek, 1980). Because women usually outlive their spouses they are often left without care at home when they become impaired. Compared to men, women were found to have fewer bed-disability days and were less likely to have a hospital contact. Women were also found to have fewer visits to physicians (Wolinsky & Johnson, 1991). When women were hospitalized, they were more likely to have shorter lengths of stay, and less likely to die (Wolinsky & Johnson, 1991).

Education was also found to have a significant impact upon health service utilization. Those with higher educational levels were found to have a greater number of physician visits than those less educated (Wolinsky & Johnson, 1991). Access to family was also found to influence service use. Elderly with greater access to family supports were more likely to seek medical care than those without family access. Wolinsky & Johnson (1991) suggest that encouragement from family members results in more physician visits. Health beliefs were found to also influence use of health services (Strain, 1991). Individuals who were more skeptical of doctors and medicine tended to have fewer medical visits than those who were not skeptical (Strain, 1991). Health values were also found to influence utilization. Strain (1991) found that those who placed greater value on health had greater utilization patterns than those who attached less value to health.

The enabling concept as identified by Andersen & Newman (1968), suggests that although people may be predisposed to use health services, they must have the means to obtain them (Wolinsky & Johnson, 1991). Enabling factors may include familial resources, income, presence of health insurance, and source of health care. According to Wolinsky & Johnson (1991) having private insurance or having Medicaid may predict health care utilization. Having private insurance was found to have a significant impact upon physician contact only. However, having a Medicaid card was found to have a significant effect on whether bed-disability days were taken, use of home health services, physician and hospital contact, and number of physician visits. Wolinsky & Johnson (1991) suggest that these findings indicate greater use of health care services by those who have Medicaid

coverage. Older people who have Medicare and Medicaid have improved access to medical care services. Both Medicare and Medicaid have enhanced the access to health care services for the poor and aged. In fact, those with Medicaid use more health services than those without medical insurance coverage (Brown, 1984). According to Muller (1988) having Medicaid coverage has a positive impact upon health care access. Muller found that those with Medicaid had higher rates of health care utilization than poor who were not covered by Medicaid. Based upon these findings it appears that having Medicaid will help increase utilization of needed health care services by the poor elderly, who are primarily female.

Need factors also determine the use of health services for older people. In order for the person to use services, he or she must perceive some illness or need for services. According to Wolinsky & Johnson (1991) perceived illness and/or need directly influence health care utilization. Other need characteristics include objective measures of the older person's capacity to engage in activities of daily living (ADL) and instrumental activities of daily living (IADL). The above need characteristics were found to be the most significant determinants of the number of medical visits of older people (Strain, 1991).

Other factors have been found to influence the utilization of health care services for the aged. Bengtson et al. (1985) found that the living situation of the older person had a significant effect on health care utilization. Those who live in extended families are less likely to use health services because of the social support they receive from their families

(Wolinsky & Johnson, 1991). As use of health services is directly related to income, those with higher incomes have greater use of services than those with lower incomes, even when health status is taken into account (Brown, 1984). Race was also found by Brown (1984) to have an influence upon health care access: whites are found to use more services than blacks.

In the next chapter the historical context of Medicare and Medicaid will be presented.

Chapter Two

Historical Context of Medicare and Medicaid

Efforts to establish public health insurance in the United States date back to the 1915 campaign of the American Association for Labor Legislation. Political efforts to tie health insurance to the 1935 Social Security Act (SSA) was an important determinant of the Medicare and Medicaid bills passed in 1965 (Brown, 1984). The passage of the SSA in 1935 set the precedent for Federal support for the poor. With its passage, SSA defined the distinction between the deserving and the non deserving poor. The deserving poor were those individuals who were poor because of old age, widowhood, blindness and disability. This group of poor was distinguished from the non-deserving poor--those who were not viewed as having legitimate reasons for their poverty (Brown, 1984). The SSA also established the distinction between social insurance for the deserving and public assistance for the non deserving poor. SSA benefits were based upon work related contributions, and were established as an entitlement by Congress. Public assistance benefits on the other hand were established at the discretion of the government and involved no contributions from beneficiaries. As public assistance benefits were means-tested and served the poor

they became stigmatized. This distinction between the deserving and the non deserving poor has influenced social welfare legislation ever since. Medicare, a social insurance program like Old Age & Survivors Insurance (OASI), was distinguished from Medicaid, a public assistance program, usually linked to welfare benefits (Brown, 1984).

Prior to the passage of Medicare and Medicaid, numerous bills were introduced in the 1940's to establish a national health insurance system but were defeated by the strong political influence of the American Medical Association (AMA), insurance companies, hospital associations among others. Apparently the AMA did not support the concept of national health insurance because of fears of diminished income among its membership. Among other bills, the Wagner-Murray-Dingell bills were defeated in 1949. These national health insurance bills supported the premise that financial means should not determine a person's access to health care. The AMA supported private insurance as the "American way" (Brown, 1984). President Truman's advisors proposed a federal plan which would limit health insurance to Old Age & Survivor's Insurance (OASI) recipients. By linking health insurance to OASI benefits, Truman's advisors hoped to avoid the stigma of welfare and thus avoid AMA opposition (Brown, 1984). In 1950 amendments to the SSA reduced demands for a national health insurance policy. Additional efforts toward health insurance were halted by Eisenhower's campaign against socialized medicine during his political campaign in 1952. The AMA lobbied against the Aime Forand bill which would have provided up to 120 days of hospital and skilled nursing care for OASI recipients. This bill was based on the premise that 60% of elderly people had yearly incomes less than

$1,000 and no hospital insurance coverage. Opponents to this bill supported a means tested welfare insurance plan which provided help only to those most in need (Brown, 1984).

It was not until 1960 that the AMA and legislators agreed that the elderly were in need of assistance to meet the increasing costs of medical care. The Kerr-Mills Act, enacted in 1960, expanded upon Federal grants for medical care available for welfare recipients under old age assistance. This act created new coverage for elderly who were not receiving cash assistance but who were too poor to afford medical care. This group of individuals was identified as the medically needy (Brown, 1984). This concept of medical need was later carried over to the Medicaid program (Stevens & Stevens, 1974). The Kerr-Mills Act left many elderly interest groups unsatisfied. As a result, the aged campaigned for SSA-based health insurance to meet the high costs of medical care, without the stigma of a means test (Brown, 1984). The Democratic Party control of 1964 assured that health insurance would be enacted. Public Law 89-97 was finally approved in 1965 and included Medicare as Title 18 and Medicaid as Title 19 of the Social Security Act amendments (Brown, 1984). It was President Johnson who signed Medicare and Medicaid into law.

Implementation required vast administration and federal funds. Medicare and Medicaid partially accomplished the goal of improving access to health care services for the elderly and the poor, while preventing the impoverishment of the elderly due to high medical expenses. However, Medicare and Medicaid became more costly than ever imagined, and

as a result, cost containment measures ultimately replaced the original goal of access to care (Brown, 1984). A description of Medicare and Medicaid coverage will follow.

Medicare Coverage

When Medicare was implemented in 1966, it was intended to protect the elderly from impoverishment following payment for acute medical care costs (Branch, et al. 1988). Proponents of Medicare expected it to become the first step toward a comprehensive national health insurance program; unfortunately this did not result. Instead, Medicare provided limited coverage for the elderly. While Medicare provided greater access for medical care for the aged, it did not include coverage for the full cost of medical care. Initially Medicare coverage did not include coverage for chronic, long term care for the aged. Medicare was later improved to provide some coverage for rehabilitation and prevention and limited long term home health services. As a result of its limited provision for long term home health services, Medicare encouraged the institutionalization of the elderly, often resulting in the impoverishment of those needing long term care (Monk, 1990).

Medicare coverage pertains to two types of medical coverage--hospital and physician. Medicare Part A provides coverage for most hospital medical care, including 100 days of skilled nursing home care following hospitalization. Financed through SSA taxes, Part A covers all individuals who are eligible for SSA benefits. Part B, on the other hand is

voluntary, not compulsory coverage like Part A. Part B covers supplemental services, including physician services, short term home health care, diagnostic tests and so forth. Individuals who are eligible for Part A are eligible for coverage. Coverage under Part B is financed through monthly premiums paid by elderly or disabled enrollees (Brown, 1984). Although Medicare was enacted to help the elderly pay for acute care, there are shortcomings in its coverage. Older persons who need chronic long term care are caught in "a no-care zone" of medical coverage (Grau, 1987). Medicare only covers between 45-49% of the health care costs of the elderly (Grau, 1987; Estes, 1989). Only a fraction of the costs for long term care is covered by Medicare.

The Medicare Long Term Home Care Catastrophic Protection Act, also referred to as the "Pepper Bill," was proposed in 1988 to address the gap in long term care. The bill was concerned with the long term care needs of the elderly, and of all persons needing chronic care. This bill recommended the training and use of informal family supports to provide care for the chronically impaired. Coverage would be self-financed through Social Security taxes, affecting only 5% of the top wage earners. Unfortunately this bill was defeated because its timing coincided with the passage of the Medicare Catastrophic Coverage Act, which did not include coverage for most of the long term care needs of the elderly (Monk, 1990). The Medicare Catastrophic Coverage Act, introduced in the late 1980's, was intended to provide additional medical coverage for Medicare beneficiaries. It was ultimately repealed because its financing relied in part on an income tax surcharge affecting 40% of the elderly (Crystal, 1990). This act pitted moderate income elderly

against the well off, creating division among the aged. It was ultimately repealed because the elderly realized that they would be paying more than the increased benefits would be worth to them (Crystal, 1990). Because of the gaps in Medicare coverage regarding long term care, some elderly, especially those with low and middle incomes, have turned to Medicaid. Medicaid is frequently used to provide coverage for the long term care needs of the elderly that are not met by Medicare (Muller, 1988).

Medicaid Coverage, Policy, and Utilization

Coverage and Eligibility

Enacted in 1965, and implemented in 1966, Medicaid was designed to fill the gaps in care left by Medicare (Brown, 1984). The Medicaid program was planned to provide comprehensive health care, including chronic long term care (Branch, et al. 1988). Medicaid provided Federal matching funds to the states for medical care for low income persons meeting certain criteria of eligibility (Harrington, et al. 1986). In most states Medicaid is funded 50% by Federal funds, matched equally by State and local funds. Federal funds are allocated on a matching formula based on state per capital income (Chang & Holahan, 1990). In some poorer states Federal funds account for as much as 83% of the total cost (Brown, 1984).

Contrasted with Medicare, Medicaid coverage of the elderly is restricted to the poor and

medically needy. In addition to providing coverage for the impoverished elderly, Medicaid coverage is provided to certain Federal categories of the non elderly. Those who are potentially eligible for Medicaid are considered the "categorically needy" (Brown, 1984). Recipients of AFDC, SSI (the aged, blind and disabled poor) are automatically covered by Medicaid. Individual states, like New York, also include coverage for the "medically needy" (Brown, 1984). Covered under this category are individuals whose medical care costs are so high as to cause their impoverishment. The eligibility criteria for the medically needy category are more liberal than for other Medicaid categories. Nationwide, 37 states provide coverage to the medically needy (Tilly & Brenner, 1987). Medically needy individuals who live in states without this category cannot obtain Medicaid coverage for skilled nursing or home care (Neushler, 1988). Covered by Medicaid are such health care services as: in and out patient hospital care, laboratory and x-ray services, skilled nursing home care, physician and home health care, prescription drugs, screening, diagnosis and treatment (State Comptroller, 1989). Medicaid is the major Federal program providing health care to the low income population (Chang & Holahan, 1990).

Eligibility for Medicaid varies from one state to another. To some extent, eligibility for Medicaid-covered care is determined more by geography than by physical or financial need (Quadagno, et al. 1991). In order to be Medicaid eligible an older person must either be poor or deplete his or her resources to reach the state's level of Medicaid income eligibility (Branch, et al. 1988). In New York State, for example, a single older person would be eligible for Medicaid if his or her income did not exceed $550 per month. Under

the surplus income program, an individual can qualify for Medicaid surplus if his or her medical needs exceed their surplus income above the Medicaid level (Medicaid surplus will be explained in greater detail later on in this chapter).

New York State has also recently included a spousal refusal policy. The spousal refusal provision allows one spouse to qualify for Medicaid only if their spouse declares their refusal to provide financial support for them. This provision protects the non medically needy spouse from impoverishment.

Medicaid Spend Down

As stated above, Medicaid eligibility differs by state of residence. In some states, individuals whose financial resources exceed the Medicaid eligibility level may qualify for Medicaid by "spending down" the amount of their surplus resources. The process of spending down assets in order to become Medicaid eligible has been documented in the literature (Quadagno, et al. 1991; Branch, et al. 1988; Liu, et al. 1990). According to Liu, et al. (1990), the spend-down process is one in which "assets are depleted and income is used to pay privately for health care until the person becomes Medicaid eligible." Once the person's assets are within Medicaid eligibility, he or she may apply for Medicaid, providing they are able to document their payments for medical expenses. The process of spending down is one in which the applicant uses her savings and other assets to pay the cost of medically related expenses, such as prescription drugs, durable medical equipment,

and often home health care services. It has been suggested (Liu et al. 1990), that the costs of prescription drugs are the primary reason for Medicaid spend-down (rather than for other community-based services), as many elderly are able to obtain assistance in the home through informal supports and relatives. This author's direct practice experience has differed. Practice experience has shown that many elderly are without the informal supports of family and need to pay for these services privately. In the New York metropolitan area, the expenses of home health care typically exceed those for medication, and are most often the reason for Medicaid spend-down.

Medicaid Surplus

Those whose incomes are just above the Medicaid cut off, yet too low to cover the costs of medical care, are caught in the "Medicaid gap," according to Quadagno, et al. (1991). Without Medicaid coverage, this group of elderly may be more at risk than those with lower incomes who clearly qualify for Medicaid. Fortunately, in some states like New York, individuals whose financial resources are within Medicaid guidelines, but whose monthly incomes exceed the Medicaid cut off, are eligible to apply for Medicaid under the "surplus" program. Under the Medicaid surplus program, individuals who are medically needy (the aged, blind, disabled) may apply for Medicaid coverage if their medical expenses exceed the difference between their income and the Medicaid eligibility level. For example, Ms. S. lives in New York, where the income limit for a single person is $550 per month. Her monthly income is $750 ($200) above the limit. She may qualify for Medicaid

surplus because her monthly medical expenses average $300. Once she is approved for Medicaid, she will need to pay out of pocket the first $200 of her medical care; the remainder will be covered by the Medicaid surplus program. This program is especially useful for elderly who are in need of extensive medical care, including continuous home health care service.

Medicaid Policy

As stated previously, Medicaid policy and eligibility differ from one state to the next (Grau, 1987). Demographic conditions within each state affect Medicaid policies and expenditures (Harrington, et al. 1986). In some states the formulas for determining eligibility are so strict that almost 50% of the poor cannot qualify for assistance (Grau, 1987). In fact, more poor do not have Medicaid coverage than have it (Kasper, 1986). New York State's eligibility requirements are less restrictive compared to other states. According to the Public Citizen Health Research Group, a consumer advocacy group, New York's Medicaid program has "broad eligibility" (State Comptroller, 1989). Except for California, New York has a higher percentage of the population participating in Medicaid than any other state (State Comptrolier, 1989). New York and California established the most liberal eligibility standards and more generous benefits than all other state Medicaid programs (Brown, 1984). Under the Medicaid program, states offer mandatory and optional benefits. Mandatory benefits are those that must be provided

under Federal law. These services include inpatient hospital care, physician services, skilled nursing care, outpatient care, home health care, lab and x-ray, diagnosis and treatment programs. Optional services are those not required by Federal law, but chosen by individual states. Optional services include prescription drugs, intermediate care, and dental care (Harrington, et al. 1986).

Medicaid policies affect eligibility, benefits, utilization and reimbursement. Policy changes in Medicaid after 1981 had a significant impact upon those at or above the poverty level. Medicaid coverage of the near-poor elderly declined more than the decline in the near-poor elderly population (Chang & Holahan, 1990). The Omnibus Budget Reconciliation Act (OBRA) of 1981 had a significant impact upon state Medicaid expenditures (Harrington, et al. 1986). OBRA reduced Federal funds for Medicaid to 3% below previous levels. As a result of OBRA, states were given more autonomy and flexibility in administering Medicaid services. Some states devised more stringent criteria for eligibility for categories of coverage, and also limited more costly services (Harrington, et al. 1986). State Medicaid policies approved in 1981 and 1982 were assumed to have a greater impact on the health care of the aged and disabled. In addition, policies adopted were intended to slow the rate of growth in expenditures and utilization of services for the aged (Harrington, et al. 1986). According to Harrington, et al. (1986) after 1981 most states increased the number of restrictions on the availability of services, but did not eliminate benefits.

Around the same time as the passage of OBRA (1981), Congress established the home and community-based waiver program. The goal of this waiver program was to respond to the growing need of the elderly for home-based care while limiting Medicaid costs (Chang & Holahan, 1990). The Medicaid waiver program was intended for aged, disabled, and the chronically ill who were in need of long term care. The goal of this program was to make needed services available in the home at 75% of the cost of a skilled nursing facility, ultimately saving the state money. Use of the Medicaid waiver program has been limited because of the massive administrative paperwork requirements of the program. Participating states must document that the waiver program is actually saving money by preventing institutionalization (Chang & Holahan, 1990).

Social welfare policy changes in other entitlement programs may also impact upon Medicaid policy. Changes in Medicare and SSI affect Medicaid eligibility. As Medicaid and SSI eligibility levels are closely tied, extension of Federal eligibility standards for SSI will also increase the number of persons who fall into Medicaid eligibility (Paringer, 1985). Medicare reimbursement policies also influence Medicaid reimbursement rates. For example, Medicaid policy regulations ensure that payment for hospital outpatient services may not exceed the amount that Medicare would have paid for the same services (Chang & Holahan, 1990). Medicaid and other means-tested programs are financed in a similar manner. Medicaid and other programs like Food Stamps are supported through regressive sales and property taxes on both State and local levels. As a result they tend to redistribute income from the working and lower middle class to the poor (Sparer, 1981). According to

Brown, (1984), if taxes were collected more progressively instead there would be greater equity between economic classes.

Exceptions to Policy

In most states laws have been established that prevent older people from intentionally impoverishing themselves by turning over their assets to others and then applying for Medicaid. New York State is now an exception to this rule--since 1989, older people have been permitted to transfer their assets (usually to family) and then apply for Medicaid assistance. While there are no restrictions or penalty periods for community-based care, individuals who need skilled nursing home care are penalized by not being able to immediately obtain Medicaid coverage. The penalty period is calculated by dividing the amount of money transferred by the average monthly cost of skilled nursing home care in the state.

Utilization of Medicaid Services

Contextual factors, including the demographic and economic environment, are viewed as impacting Medicaid utilization and expenditures (Harrington, et al. 1986). Increasingly, Medicaid money has been utilized to pay for long term care. According to Chang & Holahan (1990) approximately 50% of the nationwide Medicaid budget is currently spent on long term care. Utilization rates for Medicaid-funded care have increased at a faster

rate than every other category of state budgets (Farrell, 1989), probably because many of those with coverage are utilizing these services for chronic long term care services.

In New York, one-half of all Medicaid funds are spent on the medically needy, although they only make up one-quarter of the Medicaid population (Rubinstein, 1991). Medicaid costs in New York are high because coverage is extended to a larger segment of the population than in other states. New York has the highest Medicaid spending in the nation because it includes more categories of eligibility for coverage, offers more covered services (e.g. home care services), provides more units of its covered services, and has fewer limitations on eligibility. Currently, New York spends twice as much money per Medicaid recipient as the rest of the nation (Rubinstein, 1991). For example, New York spent $3,830 per recipient compared to $1,376 spent by California--the next highest spending state (State Comptroller, 1989). In 1987, New York's Medicaid budget accounted for approximately 20% of all Medicaid expenditures nationwide, even though New York contained only 10% of the nation's Medicaid recipients (State Comptroller, 1989). New York's costs are so much greater than other states because of the economic conditions affecting the New York area. The costs of providing services in this region are much greater, as in the length and cost of the average hospital state. The cost of the average hospital stay for the aged Medicaid population is especially greater than it is in other states (State Comptroller, 1989).

Another factor affecting the high costs of Medicaid funded services results from the

utilization patterns of those on Medicaid. Those covered by Medicaid use more health care services than others. This is seen as an indication of the greater medical needs of older adults with lower socioeconomic status (Wolinsky & Johnson, 1991). They tend to delay seeking help because they lack health care coverage--often resulting in their worsening health and thus greater need for medical care. However, once coverage is obtained there is an increased use of services (Stahl & Gardner, 1976; Wolinsky, 1982). Wolinsky & Johnson (1991) attribute this high rate of consumption to the fact that those applying for and covered by Medicaid are more likely to have greater health needs than those who chose not to apply. Increased utilization of services may also be reflective of fragmentation in the delivery of health services typically provided to Medicaid clients, leading to higher rates of utilization (Wolinsky & Johnson, 1991).

Medicaid spending for long term services increased dramatically during the mid-1980's, accounting for more than 50% of all Medicaid expenditures (Chang & Holahan, 1990). Medicaid coverage for long term care includes skilled nursing facility and home health care services. Together these services comprise a significant portion of a state's Medicaid expenditures (State Comptroller, 1989). Long term care costs in New York in 1989 accounted for 81% of the State's total Medicaid costs, compared to only 66% in Michigan (State Comptroller, 1989). Growth in long term care overshadowed spending for acute care services. This increase in spending was due to a 1.5% increase in the number of long term care recipients and more intensive use of services (Chang & Holahan, 1990). Over the past decade Medicaid consumption for all long term care services increased, but

spending for home health care services grew the most (Chang & Holahan, 1990). The rapid growth in home health care services, an average of 35% per year, was due to an overall 15% increase in recipients (Chang & Holahan, 1990; State Comptroller, 1989), increased reimbursement rates, and increased provider participation (State Comptroller, 1989). These growth rates can be tied to expansions in Medicaid eligibility and covered services through state initiatives and Congressional legislation and to increased utilization by those receiving Medicaid.

New York provides two types of home care service funded through Medicaid: skilled care requiring medical supervision, and personal care assistance with basic and instrumental activities of daily living (ADL and IADL). Services provided in New York State are the most extensive in the country. In 1987 for instance, 56% (862.4 million) of the total dollars spent on home care services were expended on New York State recipients (State Comptroller, 1989). Medicaid growth in long term care may also be attributed to home and community based Medicaid-waiver programs throughout the country (including New York) which have expanded non-institutional long term care services (Chang & Holahan, 1990). Approximately 24 states, including New York State, presently fund personal care services. Personal care services are optional for the states, which explains why only about one-half of the states cover them (Oktay & Palley, 1991). Only 10% of Medicaid dollars are spent on medical services, the rest goes to pay for personal care services previously provided by informal supports (Rubinstein, 1991). Medicaid is the largest provider of personal care services in the U.S. (Oktay & Palley, 1991). Home care services provided by

Medicaid are replete with problems (Oktay & Palley, 1991). Problems cluster around personnel difficulties in recruiting, retention, low pay scales, poor working conditions, and lack of career development for home care workers (Oktay & Palley, 1991). The home care workers, predominantly female, are clear examples of the working poor. These women, sometimes elderly, are on the verge of poverty themselves. Proposed home care cuts in New York pose the potential for the unemployment--and ultimate welfare dependency of these women. Other significant problems stem from the lack of administrative coordination, variations in restrictions from state to state (Oktay & Palley, 1991), and lack of consistent training and supervision.

Nursing home costs increased by 3.9% per year between 1984 and 1987, resulting from a 1.7% increase in recipients each year (Chang & Holahan, 1990). While virtually all skilled nursing facilities accept Medicaid patients, the industry tends to show preference for those who are able to pay privately. Federal guidelines enable nursing homes to refuse admission of Medicaid patients (Muller, 1988). It is no secret in the aging network that those who are able to pay out of pocket for at least several months of a nursing home stay will be given preferential treatment to those on Medicaid. The availability of these private care dollars to the facility is often essential to the home's financial management (Sidel, 1986). After entering a nursing home as a private pay patient, it is easier to qualify for Medicaid than while living in the community. According to Muller (1988), this ultimately leads to the use of institutional rather than community based long term care.

In recent years, Medicaid costs, especially for long term care, have increased dramatically. Concurrent with increased expenditures, practice experience has indicated increased difficulty in the ability of eligible applicants to obtain coverage. The obstacles to obtaining Medicaid coverage will now be explored.

Obstacles to Medicaid

Obstacles to Access and Utilization

The legislative separation of Medicaid from Medicare is perhaps one of the greatest limitations of the Medicaid program (Brown, 1984). Medicare is essentially paid for by all and will ultimately benefit everyone as they age. Medicaid is also paid for by the majority of working people through taxes, but will only benefit the poorest members of society. As a result, Medicaid has very limited political support. In addition, Medicaid and other means tested entitlement programs are frequently targeted for cutbacks and are often viewed as the reason for budgetary deficits. Medicare represents the "deserving" aged, while Medicaid has come to represent the "non deserving." Economic and political shifts often determine the dividing line between the "deserving" and "non deserving" poor. It has been suggested by Brown (1984) that a single insurance program for the poor and elderly would have created less of a stigma for the poor aged in regard to health care coverage.

Because Medicaid eligibility is tied to state welfare guidelines, access often has a high

stigma associated with it (Estes, et al. 1984). From its earliest implementation the program appeared to be linked to welfare. To many elderly Medicaid has a welfare stigma attached to it. "If it's welfare, I don't want it," expressed the attitudes toward Medicaid of many poor elderly (Alexander & Podair, 1969). Even though Medicaid was designed to cover most of the health care costs of poor elderly, only about 36-40% of those eligible have Medicaid coverage (Estes, 1989; Chang & Holahan, 1990). According to Oktay & Palley (1991) Medicaid limits its access to the poorest and then only serves about one-half of those eligible--among the elderly only one-third are covered (Chang &Holahan, 1990). Factors associated with stigma may account, to some extent, for the low Medicaid enrollment of those potentially eligible for this entitlement. Although there are a number of entitlement programs geared to the low income elderly, less than one-third of those eligible even apply for either Food Stamps or Supplemental Security Income (Girshick & Williamson, 1982). According to Girshick & Williamson (1982), many elderly do not apply for assistance because of the stigma associated with welfare, lack of information about eligibility, and lack of information about how the specific entitlement can be helpful to them.

In addition to the stigma associated with Medicaid, other variables account for this low enrollment phenomenon. Issues related to eligibility criteria, application procedures, provider acceptance and reimbursement are a few of the obstacles to Medicaid access for older people. Older women, because of financial vulnerability and chronic illness, are those most often confronted by the obstacles to Medicaid coverage. These barriers to access

essentially represent a gender specific problem because of the high representation of women among Medicaid beneficiaries (Muller, 1988).

Although the overall enrollment of the Medicaid program is large, only about one-third of the eligible elderly are actually covered by Medicaid (Chang & Holahan, 1990). Obstacles to access, including restriction on eligibility, have prevented many of the elderly poor from obtaining coverage (Brown, 1984). It has been estimated that between 40-67% of the impoverished are not eligible for Medicaid because of categorical or income restrictions (Medicaid/Medicare Management Institute, 1974). Among the poor, the elderly are even less likely to be covered by Medicaid. To some extent Medicare coverage reduces the incentive for poor elderly to apply for Medicaid (Chang & Holahan, 1990). As suggested above, as there is no stigma associated with Medicare, some poor elderly do not apply for Medicaid. To a limited extent Medicare may indirectly serve as an obstacle to Medicaid coverage for some elderly poor.

Medicaid was originally designed to provide low income persons with the same type of access to health care as was available to the rest of the population (Chang & Holahan, 1990). What has occurred since its enactment differs from its original design. The type of medical care available to Medicaid recipients differs from that available to those not covered by Medicaid. Because Medicaid payment levels are significantly lower and reimbursement takes longer than under Medicare, many private physicians refuse to accept Medicaid patients (Muller, 1988). A total of one-fifth of all medical practitioners do not

accept Medicaid patients (Burney, Schieber, Blaxall & Gabel, 1979). Differences in the rates of reimbursement explain why these providers do not accept Medicaid patients. Reimbursement for Medicaid patients is based on a fee schedule, whereas Medicare uses customary prevailing fees (Medicare/Medicaid Data Book, 1990). In general, Medicaid reimbursement rates are 25% less than those of Medicare (Burney, et al. 1979). Paringer (1985) suggests that increases in Medicaid reimbursement rates would make medical providers as willing to accept Medicaid patients as private pay patients.

Other obstacles to Medicaid access result from the administrative and bureaucratic administration of the Medicaid program. According to Morrison (1983) fragmentation and depersonalization are major barriers to Medicaid services. A study conducted after the enactment of Medicaid indicated that there was a general lack of knowledge about Medicaid, what it covered, general confusion of Medicaid with Medicare, and belief that one had to be on welfare in order to be eligible for Medicaid (Alexander & Podair, 1969). Thirty years later, general confusion on the part of the public about Medicaid continues--how it differs from Medicare, and how eligibility is determined. As early as 1967, the year after the implementation of Medicaid, various obstacles to Medicaid were identified (Alexander & Podair, 1969). Findings indicated that there were lengthy delays in processing applications, and delays in receiving a Medicaid card after approval; applicants were unable to reach the Medicaid office because of constantly busy telephones, nor were they able to obtain a physician who would treat Medicaid patients. In addition, there were complaints about the quality of care given by Medicaid practitioners (Alexander & Podair,

1969).

As a result of this study, a campaign was begun in 1967 in New York City to help educate New Yorkers to the benefits of Medicaid. A report developed from this campaign indicated that individuals who were potentially eligible for Medicaid did not apply because of a lack of understanding about Medicaid, misconceptions about the meaning of the program, and a reluctance to give financial information needed to determine eligibility (Alexander & Podair, 1969). Researchers were able to increase public awareness of the Medicaid program by using a health oriented campaign, which emphasized the goals of this public health program. They attempted to differentiate Medicaid from welfare, explaining that Medicaid was a tax supported program for the medically needy. In addition, the campaign explained how an aged person could be covered by both Medicare and Medicaid and then have little or no out of pocket medical costs (Alexander & Podair, 1969).

Many of these initial problems continue to plague the Medicaid program. Based on this writer's experience, it appears that there is little or no public relations outreach toward the potentially eligible Medicaid population. The Medicaid administration appears to be focusing its efforts upon cost containment measures, and preventing those who are ineligible from receiving coverage. These efforts have driven the Medicaid program, making it often difficult for the eligible needy to obtain essential coverage. An example from current practice illustrates some of the difficulties in obtaining coverage:

Ms. M., an 86-year-old widowed woman suffering from arthritis, severe emphysema and hypertension, applied for Medicaid in January 1993 in order to provide coverage for her extensive home care needs. Although Ms. M. was clearly eligible for Medicaid, her initial application was rejected. The local Medicaid office stated that she had not submitted all the necessary documents. Although these documents had already been submitted by her social worker, they were submitted again. When Ms. M. was again determined ineligible for Medicaid, her social worker represented her at a "Fair Hearing"--the due process of the Medicaid program which preserves an applicant's legal right to Medicaid. The determination of the Fair Hearing was in favor of Ms. M., and Medicaid was ordered to provide coverage for her. The Medicaid office, while agreeing to provide coverage for her, determined that she should be able to manage with only six hours of home care service per day. Because this limited amount of care placed Ms. M. at risk, her social worker requested another Fair Hearing. Following the second Fair Hearing it was determined that this woman was in need of continuous supervision and would require the services of two 12 hour home care workers. It took a total of twelve months and unprecedented hours of social work advocacy for Ms. M. to obtain Medicaid coverage and the appropriate level of home care services she needed. It was not until March of 1994 that Ms. M received the coverage and care for which she was eligible.

This rather extreme example of some of the obstacles to Medicaid is becoming more commonplace. Efforts by the Medicaid administration to limit Medicaid access appear to have driven eligibility specialists to attempt to create practical obstacles to access. The

value of due process through the Fair Hearing is also illustrated by the above case example. Practice experience suggests that as the Medicaid administration becomes more adversarial, the use of Fair Hearings will increase in an effort to obtain greater access.

Among those who are rejected for Medicaid, slightly less than 25% seek Fair Hearings (Quadagno, et al. 1991). According to Yarrow (1991) those who are denied eligibility need to know why so they can contest at a Fair Hearing. Fair Hearings are essential to the right of applicants for access. Few states actually adhere to Federal eligibility regulations. For example, an eligibility determination is necessary within 30-45 days in most states. In New York, South Carolina, and Illinois, a shorter limit (30 days) is imposed on determination (Yarrow, 1991). Muller (1988) suggests that despite the mandated time frames, many applicants wait considerably longer until eligibility is determined. As illustrated by the above case example, New York clearly does not consistently adhere to the 30-day time frame for determinations of eligibility.

Although Fair Hearings are helpful to potential recipients, there are additional obstacles within the Fair Hearing process. The Medicaid administration has frequently failed to provide potential clients with written notification explaining adverse decisions (Yarrow, 1991). The failure of Medicaid to provide information regarding the reason for the denial denies the applicant an opportunity to effectively challenge Medicaid's initial determinations. Frequently Medicaid's notifications provide only limited information regarding determinations. Local Medicaid offices do not consistently ensure that

applicants are informed that they have a right to a Fair Hearing, do not make records easily accessible to clients, and do not provide sufficient time to request a Hearing and records (Yarrow, 1991). In addition, the print on notices is usually too small for elderly people to read, and the material is often written only in English (Yarrow, 1991). These represent additional administrative obstacles to Medicaid access.

Older people who are able to afford legal representation throughout the Medicaid process appear to have greater access to Medicaid. Through legal counsel these individuals, usually upper middle class, are able to take advantage of legal but evasive means to obtain Medicaid eligibility. Currently, some attorneys are specializing in elder-care law, catering to well-to-do clientele wishing to take advantage of the loopholes in Medicaid law. As a result, those able to afford their legal fees are able to obtain greater access to this medical program, originally designed for the most impoverished (Grau, 1987).

One of the obstacles to Medicaid for social workers and other advocates is in obtaining accurate financial information about the income and assets of the older person (Schultz, 1984). As this information relies heavily upon the self-report of elderly clients, there are often problems of inaccuracy. Schultz (1984) found significant under reporting of income by elderly applicants. The incidence of under reporting was found to be larger for persons with higher incomes, and relatively small for those at the lowest income levels. Sometimes full financial information is not provided because the older person has neglected to reveal the presence of additional financial resources. Applications based upon inaccurate financial

information will most likely lead to ineligibility as Medicaid eligibility specialists perform computerized bank searches for hidden assets.

The Medicaid "Gap"

Individuals who are slightly above the Medicaid eligibility level, yet too poor to afford the cost of adequate medical services, fall through the cracks and into the Medicaid gap. According to Quadagno, et al. (1991) those most likely to fall into this gap are those with a continuous work history and those receiving small pensions. These individuals, the "near poor," are more at risk of not receiving care because they are not covered by Medicaid nor do they have the financial means to obtain care (Estes, et al. 1984). Older people who fall into the Medicaid gap are difficult to identify. Some attempt to apply for Medicaid under the spend-down or surplus programs, but are rejected. Quadagno, et al. (1991) suggest that those in the Medicaid gap may be screened out through an initial telephone call by intake workers who do not take the time to explain the various options for Medicaid. Others in the "gap" may never formally apply because they think they are not eligible based on the advice they receive from friends, neighbors, and so forth (Quadagno, et al. 1991).

Medicaid and Older Women

It is estimated that only 5.7% of the aged have coverage through both Medicare and

Medicaid (NCHS, 1990). Those persons who have dual health coverage through Medicare and Medicaid are usually older, poorer, and more likely to be female than those covered by Medicare only (Rhymer, 1984). According to Cronin (1987), in New York City, 84% of the Medicaid population are older women. Muller (1988) states that women represent two-thirds of those on Medicaid and attributes this to the poor economic conditions of women in our society. Because women are highly represented among the Medicaid population, Medicaid policy regarding income and assets has great impact upon the economic conditions of older women (Muller, 1988). Women covered by Medicaid are usually older, sicker, and more likely to use health care services at a high rate than those without Medicaid (McMillan, 1983). Health care services that are covered by Medicaid are not always sufficient to meet the needs of older women who wish to remain in their own homes (Grau, 1987). As a result, many older women are forced to seek institutional care because no other long term care alternatives exist for them.

Chapter 3

Methodology: Research Design and Plan for Implementation

Introduction

As indicated by the foregoing literature review, there are numerous obstacles to Medicaid coverage for the elderly. The goal of this research project was to identify both the obstacles to, as well as the facilitators, of Medicaid coverage experienced by older women and their advocates. It was anticipated that some of the obstacles identified by the literature would be confirmed by this study. In addition, it was anticipated that other obstacles not indicated by the literature would be discovered. As the literature has not identified the facilitators to access, those discovered by the study will be useful to practitioners and policy makers alike. The primary focus of this study was to identify the kinds of obstacles experienced by advocates of the elderly and to determine the specific strategies they have developed to overcome these barriers. In identifying the obstacles to and facilitators of Medicaid access, it is expected that research findings will help advocates for older persons obtain greater access. Client interviews were also be conducted to provide the clients' perspective to the

difficulties encountered during the application process. It is also predicted that practice and policy recommendations will be applicable to other entitlement programs as well.

Study Design

The Advocate Perspective

A large sample of advocates for the aged were queried through self-administered questionnaires. One hundred two advocates experienced in working with the elderly were asked to identify the obstacles to Medicaid coverage from their perspectives. By using a large sample of advocates it was possible to identify the recurrent obstacles and problems encountered by advocates for the aged. Through using a varied sample among multiple sites it was possible to see if there were any differences in access between the agencies and professional disciplines. This sample of advocates was drawn from the memberships of the East Side Council on the Aging (ESCOTA), the Murray Hill Inter-Agency Council on Aging (MHIAC), the New York City Chapter of the National Association of Social Workers (NASW) Committee on Older Persons, and other similar community-based forums. In addition, social workers and other advocates affiliated with the New York City Department for the Aging's (DFTA's) case management programs were included.

In order to avoid duplication, advocates affiliated with more than one of the above organizations were asked to complete only one questionnaire. A sample of advocates

currently involved in Medicaid applications were interviewed in greater depth in order to evaluate access problems.

It was assumed that client advocates would identify a number of barriers to accessing Medicaid. Some of these anticipated barriers to access were:

(1) It was anticipated that difficulties encouraging some eligible persons to apply would be one of the most challenging problems of access of advocates.

(2) It was anticipated that problems tracking the progress of the application following submission to the Human Resource Administration would be viewed as another hurdle to services for the client.

(3) As suggested by Schultz (1984) obtaining accurate financial information from clients would serve as another obstacle to access.

(4) It was anticipated that the perceived adversarial relationships between the advocate and Medicaid offices granting approval for coverage and the Medicaid division allocating home care coverage--the Community Access Services Agency (CASA) would also serve as a barrier to accessing coverage for clients.

The self-administered questionnaire focused primarily upon closed-ended questions. However, advocates were encouraged to provide additional descriptive qualitative information throughout the questionnaire. It was anticipated that client and advocate perspectives to the application process would complement each other.

Client Interviews

The study also focused on clients at various points in the application process in order to identify the facilitators and obstacles to Medicaid for these women. Interviewing clients in two phases of the application process would assure a more complete client perspective to the application process and also provide information on two phases of the process. The first group of clients were those who had applied, but have not yet received Medicaid coverage. The second group of women were those who obtained Medicaid coverage during the twelve month period prior to the study. Based upon practice experience it was anticipated that some clients would be become immobilized by obstacles at various stages throughout the application process. The findings would be used to identify the specific obstacles throughout the application process, providing valuable information to professionals in the field of aging services.

Application Phase

The first group of women to be interviewed were those currently in the process of application to Medicaid. During a four month period of time, all female clients of Project SCOPE who were in the process of applying for Medicaid were interviewed to determine what obstacles, if any, they encountered. Understanding what these obstacles were would provide valuable information for training, practice, and policy. In addition to identifying barriers to accessing coverage, attempts were made to identify what factors helped facilitate their access to

Medicaid. It was hypothesized that those who had simple financial histories (i.e., have not transferred assets, or liquidated securities) would obtain access more quickly and with less difficulty. In addition, it was hypothesized that children or significant others would serve as facilitators during the application process.

Post-Application Phase

An additional group of older women who had Medicaid coverage were interviewed to identify what obstacles and facilitators were encountered when they applied for Medicaid. All female clients of Project SCOPE who had received Medicaid within the prior 12 months were interviewed. This twelve-month time frame was selected because of the frequency of mild memory impairment in the older population. It was anticipated that memory recall within the past twelve months would remain more accurate than for longer time frames. It was hypothesized that the most common barriers to access would be lack of sufficient documentation (e.g., bank records, copies of financial transactions) needed to demonstrate financial eligibility. The loss of documentation following submission to the local Medicaid administration was anticipated to be another problem affecting access. Other anticipated obstacles were delays in obtaining eligibility because of hospitalization, changes in family composition (e.g., death or nursing home placement of a spouse), and transfer of assets prior to application. Analysis was made not only to assess the access obstacles for this group of individuals, but also to evaluate what factors (e.g., assistance of a knowledgeable advocate) helped them access coverage.

Assessment Tools

The assessment instruments were developed to focus upon the most salient questions and issues related to each respondent group. In addition to obtaining general descriptive information about clients and advocates, an assessment was made to determine the impediments to access throughout the phases of application, facilitators to access, and how clients managed throughout the process. The client questionnaires were primarily qualitative in nature, while the advocate questionnaire focused more upon quantitative questions. See addendum for assessment instruments.

The use of combined quantitative and qualitative instruments were used to obtain more in-depth outcome measures. The combination of these methods provided more complete information than could be measured by either method alone. Use of the qualitative method during the client interviews provided more in-depth descriptive information about the clients, their individual situations, and so forth. Using the quantitative method for the advocate questionnaires provided the researcher the opportunity to determine if there were any significant differences in access to barriers and strategies to Medicaid coverage among the different advocates queried. Use of this combined method for data gathering suggests a different plan for data analysis than would be used by either method alone. Quantitative data was analyzed by looking at measures of central tendency and frequency distributions (SPSS was employed in this analysis). Qualitative data was analyzed by looking at trends and themes within each respondent group. Qualitative data was also be analyzed within each question and

focus area. Responses were evaluated according to themes and categories.

Project Goals and Objectives

In summary, the goal of this study was to provide information regarding the facilitators and obstacles to Medicaid for older people, especially for older women. This information would be used to develop training, practice, and policy recommendations. Specifically, the plan was to develop practice recommendations for interventions with older female Medicaid applicants. It was anticipated that findings would have relevance to other entitlement programs as well. In addition, the author would utilize professional contacts within the Human Resource Administration to make recommendations regarding access to their Medical Assistance Program.

Implementation of the Study

The study began with a two pronged approach--interviews with clients and outreach to advocates occurred in close proximity to each other. Outreach for this research study was initially begun in June 1992, with a presentation at an inter-agency council on aging meeting. The goal of this initial presentation was to inform community representatives about the research project and to enlist their help and cooperation in completing the advocate questionnaires. The bulk of the outreach to advocates did not occur until late September 1992. Outreach efforts were most concentrated between September 1992 and January 1993.

All client interviews were conducted in July and August 1992.

Client Interviews

During the months of July and August 1992, in-person qualitative interviews were conducted with female clients of Project SCOPE who met the criteria of the study; they were in the process of applying for Medicaid, or had received Medicaid within the past 12 months. Case managers at Project SCOPE were asked to submit the names of their female clients who met the above criteria. A large percentage (almost 80%) were found to be unsuitable for interviewing. Cognitive impairment on the part of these women was the primary reason. Other clients were not interviewed because their case manager determined that they would not be appropriate respondents because of mental health problems.

The fact that so many of those meeting the study's explicit criteria for inclusion were excluded from interviewing resulted in a much smaller sample of women than anticipated in each group. It was anticipated that Project SCOPE clients would easily provide a larger pool of appropriate clients for interviewing. This assumption was based upon the large number of clients being served by the program (over 200). Although this was initially surprising, it was understandable within the context of Project SCOPE's services and client base. Program clients who are most in need of the medical services provided through Medicaid are often too physically frail and/or too cognitively impaired to participate in such a study. A decision was made to not go outside Project SCOPE for client interviews because of issues of client

confidentiality and the lack of a trusting relationship with clients outside Project SCOPE. Because of the decision to not interview clients outside of Project SCOPE, the client interviews became a smaller part of the overall study than originally anticipated. Client case stories included in this study will be included to illustrate examples of the kinds of obstacles encountered by elderly applicants, rather than demonstrate statistical trends and frequencies.

Interviews conducted with female Project SCOPE clients were in-depth and qualitative (see interview schedule). Each woman was asked to describe the process and experience of her application (and acceptance) to Medicaid. Several women were unable to provide details of the process of application because the application had been processed primarily either by their Project SCOPE case manager, or by a family member. In two cases follow-up interviews were conducted with the case manager or with the family. A total of eight women were interviewed. Each interview lasted between 45 and 60 minutes. In one situation, the researcher was asked to leave because the client became too fatigued to continue. The interview was completed at a later date.

Advocate Outreach Efforts

Concurrent with client interviews, a questionnaire designed for social workers and other advocates was pretested. The staff of Project SCOPE was the target group for this pretesting. Additional changes and refinements were made to the questionnaire following pretesting. In September 1992 a full scale outreach was scheduled to begin.

Initially it was anticipated that an outreach into the general social service and legal communities would yield sufficient data. The initial plan was to speak at community agencies serving the elderly and distribute questionnaires to these groups. This strategy was changed when it was found that not all community-based agencies were sufficiently involved in assisting with applications to Medicaid. Workers at such agencies appeared to have limited experience in preparing Medicaid applications. Staffs at these agencies were found to complete five or less Medicaid applications per year. Some workers were found to complete only one or two applications per year.

This finding sharply contrasted with the reported activity of social workers and advocates who attended the Citywide Medicaid Advisory Council. In September 1992 the research proposal was presented to the Citywide Medicaid Council. One of these advocates was found to complete up to 2,446 applications per year. The Council is sponsored by the department of Public Affairs at Medicaid, and comprises representatives from various organizations, including those representing hospitals and advocacy groups. Individuals who attended this meeting were well versed and experienced in the application process and provided rich responses. Information from their completed questionnaires strongly influenced the research strategy for the remainder of the study. At this point a decision was made to reach out to the individual borough-based Medicaid Advisory Councils throughout the Metropolitan area.

During the months of September 1992 through February 1993 the research study was presented and questionnaires distributed at each of the borough Medicaid Advisory Council

meetings (Manhattan, Queens, Brooklyn, Bronx and Staten Island). As mentioned earlier, those who responded to the questionnaire were involved in a high volume of Medicaid applications each year. Individuals who were most involved in this activity worked in hospitals rather than in community-based agencies.

In addition to collecting questionnaires from the Medicaid Advisory Councils, outreach efforts were also made to include community-based organizations that served the elderly. The Inter-Agency Councils (IAC's) throughout the Metropolitan area were utilized to reach representatives from various social service organizations. For example, the East Side Council on Aging, the Murray Hill Inter-Agency Council on Aging, the West Side Inter-Agency Council on Aging and the Manhattan Boro-wide Inter-Agency Council on Aging were councils in which this researcher presented her study and distributed questionnaires to the membership. The response rate from such councils was substantially lower than from the Medicaid Advisory Councils (31% versus 55% respectively). This difference in response rate possibly reflected the greater variety of membership in the IAC's as compared to the Medicaid focused councils. The Medicaid Advisory Council members tended to be more concerned about Medicaid related issues by virtue of their practice and participation in the Council.

Outreach efforts were also made to individual agencies serving the aged. Some of these agencies included: Search and Care, the Jewish Association for Services for the Aged, the Burden Center on Aging, the Lenox Hill Neighborhood Association, and the Stanley Isaacs Center on Aging. Efforts were also made to include the legal/advocacy community in this

study. The study was presented to two legal subcommittees--the Legal Problems of the Aged Committee of the Bar Association and the New York Country Lawyer's Association. Unfortunately, these legal forums were not profitable for obtaining study data. Most attorneys who specialized in Medicaid Law indicated that they did not directly assist elderly clients in the application process. Instead, these attorneys would contract private geriatric care managers (usually MSW level social workers) who would assist with the application process. Attorneys were called upon for consultation on Medicaid Law prior to application regarding the transfer of assets, establishing irrevocable trusts (to shelter surplus resources) and so forth. Attorneys also represented clients at Medicaid Fair Hearings when there was a denial from Medicaid. Several attorneys did complete the questionnaire and their information is contained in the overall study findings.

Motivation for the Research

The impetus for the study evolved out of the increased difficulty experienced by Project SCOPE staff when assisting Medicaid applicants. Difficulties were evidenced by the increased length of time needed to secure Medicaid approval. Instead of taking up to three months to obtain Medicaid approval, it took up to 13 months, in one case, to obtain approval. Delays in demonstrating client eligibility frequently appeared to be related to the loss of documents after submission to Medicaid. Other obstacles were attributed to the bureaucratic structure of the Medicaid system, and/or a perceived lack of competence on the behalf of Medicaid personnel. I wanted to find out if this experience was specific to Project SCOPE staff, or if

staff at other agencies experienced similar difficulties when assisting older Medicaid applicants.

In the event the problem was specific to Project SCOPE staff this would indicate the need for additional training of staff in Medicaid rules and regulations. However, if these problems prevailed in other social service organizations, it would indicate the need for greater exploration into the specific sources of the problem. The outcome of the study would indicate the need for intervention, either in training, advocacy, or political intervention. In summary, the overall purpose of the research was to improve the access for Medicaid coverage for the elderly population, with special focus upon the unique access problems of older women. Findings from this study could assist a wide range of social service advocates in varied work sites and could also be applicable to improving access to other government-funded entitlements and benefits.

Development of the Questionnaires

Advocate Questionnaire

The advocate questionnaire was based upon practice-oriented questions emanating from the central research question of the study. Practice experience in supervising Medicaid applications indicated several areas in which staff appeared to be devoting their time and efforts. For example, from the researcher's perspective it appeared that significant amounts

of time were spent assisting elderly applicants in locating the numerous documents needed for application to Medicaid. It was important to confirm whether this was indeed the case. In addition, if this was confirmed, I wanted to find out how much time was actually spent on this activity. Did the amount of time differ from agency to agency? Were workers at other agencies also spending their time on this activity? What other activities were workers spending their time on? These and other questions formed the basis of the development of the initial advocate questionnaire. The questionnaire was revised several times throughout the pretesting phase of the study. Based upon the responses of the pretest group, the questionnaire was revised to make the questions clearer and more specific.

The Client Questionnaire

The client questionnaire was developed to obtain from the client's perspective, their motivation for and experience in applying for Medicaid benefits. Because advocates and clients have similar goals of obtaining benefits but different motivations, expertise and experience, I wanted to capture the clients' perspective in this study as well. Two client questionnaires were developed--one for those who were in the process of applying for Medicaid, and another for those who had already obtained Medicaid approval. The two clients' questionnaires were essentially similar in the types of questions asked. Where they differed was in the timing of the interview in relationship to their application to Medicaid. One client questionnaire ("pending" Medicaid approval) was for clients who had applied for Medicaid but who had not yet obtained approval. The other client questionnaire ("approved")

was for clients who had received Medicaid approval within the past 12 months. A cross-sectional approach was used in the study instead of a longitudinal approach because of the frailty of the elderly population interviewed. The increased probability of nursing home placement or death for this population would make a longitudinal study impractical.

The Questionnaires

Advocate Questionnaire

The advocate questionnaire was developed to obtain practice-oriented information from social workers and other advocates. I wanted to find out if difficulties were also experienced by other workers in accessing Medicaid for their clients. In addition, I wanted to also find out what kinds of strategies were used by advocates to overcome obstacles. When the questionnaire was finally revised, it was 11 pages long and contained a total of 36 questions (see the addendum). Because the questionnaire was a combination of both quantitative and qualitative questions, the information obtained differed from questionnaire to questionnaire. Respondents were asked to be specific and detailed in their qualitative responses, and were encouraged to attach additional pages, or to write on the back as needed. The cover sheet of the Advocate Perspective Assessment contained the respondent's informed consent, and an introduction to the study. The introduction explained that the research study was designed to identify both the obstacles to as well as the facilitators of Medicaid coverage for older women. In addition, the introduction emphasized the confidentiality of the study, and that the

information obtained would be used for research purposes only. The researcher's name, address and telephone number were given in the event the respondent wanted additional information or had any questions.

The majority of questionnaire items focused primarily upon the process of obtaining Medicaid access and coverage for Medicaid-funded home care services, since women often survive their spouses and need care at home. Questions focused upon these two areas because coverage for Medicaid-funded care, including home care services, is vital for community dwelling low income elderly. Practice experience suggests that the majority of elderly who apply for Medicaid do so that they may qualify for home care services financed through Medicaid (Project SCOPE, 1993). Because Medicaid and Medicaid funded home care are so intertwined, the study of Medicaid funded home care requires the study of Medicaid.

The questionnaire began by focusing upon descriptive information about the respondents, asking such questions as age, gender, and ethnic background. Respondents were asked about their level of education, experience in the social services, job function, title, place of work, as well as their experience working with the aged population. The above questions were designed to describe and analyze the respondents. The goal of this part of the questionnaire was to give the researcher background information about the respondents so that an assessment could be made of the respondents as a congregate group. Information from these questions could also be used to look individually at respondents who provided helpful and or innovative strategies. Looking closely at such individuals' responses could determine if there

was any correlation between background, training, experience level and effective intervention strategies.

The next set of questions focused upon the characteristics of clients served by the agency/individual respondent. These questions would provide information as to whether difficulties in accessing coverage were more likely to be experienced by different ethnic groups, or correlated with the client's native language. Respondents were then asked specifically about their experience in helping clients apply for Medicaid. The number of applications processed per year, their experience in accessing coverage for their clients, difficulties tracking, obtaining accurate financial information, documentation and so forth, were among the questions asked. Respondents were also asked to describe their experience in interfacing with the Medicaid system. The helpfulness of the Medicaid/CASA workers in assisting them or their clients was among the questions asked of respondents.

Advocates were then asked how often they utilized Medicaid Fair Hearings (a legal procedure) to protest determinations of eligibility and home care service authorization. Use of the Medicaid Conference (not a legal procedure) was explored to determine respondents' experience using this more informal method of advocacy. Respondents were also asked if they had been trained by Medicaid as pre-screeners. If they had undergone this training, they were able to circumvent some steps in obtaining Medicaid coverage for their clients. Advocates who completed this one-day training were asked to indicate whether or not they found it helpful in expediting their clients' access to Medicaid.

Advocates were asked to indicate the amount of time they spent on specific tasks related to obtaining Medicaid approval. Respondents were asked for the total amount of time they spent gathering, photocopying, and submitting documents, and in written and verbal correspondence with clients and Medicaid affiliated staff. Respondents were asked to identify where they thought difficulties occurred for them and their clients throughout the Medicaid application process.

More specifically, social service advocates were asked to describe the intervention strategies they employed at various stages throughout the application process. For example, these respondents were asked to indicate the types of strategies they used when submitting documentation to Medicaid. In addition, they were asked to describe the strategies they employed when collaborating with CASA/Medicaid. Finally, all advocate respondents were asked to provide any practice wisdom they had regarding the access of Medicaid for their clients.

Client Questionnaires

The purpose of the client questionnaire was to obtain, from the client's perspective, what the process of applying for Medicaid had been like for them. It was anticipated that information derived from clients would provide insight into the impact of the obstacles upon clients. The client questionnaire was 13 pages long and contained a total of 59 questions. The majority of questions were open-ended allowing the client an opportunity to respond to each question

on an individual basis. The cover sheet of the Assessment Instrument included the informed consent form and an introduction to the study. The informed consent stressed the confidentiality of the study and that participation in the study would not affect any of the services received by the client. The introduction explained the purpose of the research study and the types of questions that would be asked. The questions asked were simple ones that most alert older persons would be able to answer. Close-ended questions focused upon demographic information, such as age, place of birth, marital status, and living arrangements. In addition, questions related to work history were also asked to determine if there were any differences in attitude toward applying for Medicaid between those women who had worked outside the home and those who had not. The next set of questions focused upon the individual's medical coverage, which would indicate their need for the services covered under the Medicaid program. Each respondent was asked what she would do if she needed medical care that was not covered under her current medical plan, and whether she had ever gone without food or other essentials in order to pay for her medical expenses.

Respondents were asked what motivated their decision to apply for Medicaid; whether they had ever applied for Medicaid coverage before; and what it was like for them to apply for Medicaid. Each respondent was asked to go into greater depth about the process of applying for Medicaid; who had helped her to apply, and what she experienced as difficulties during the process. Next, respondents were asked whether they agreed or disagreed with several statements related to Medicaid and other government-funded entitlements. Finally, each was asked about her satisfaction with the assistance she was receiving from various agencies

including Medicaid. In summary, the client questions complemented those asked of the advocate, by asking related questions but from a different perspective. In contrast with the advocate questionnaire, the client questionnaire also focused upon the client's motivation for and personal experience in applying for Medicaid-funded benefits.

Administration of the Survey Instruments

Advocates Questionnaire

The questionnaire was distributed through a variety of means, with almost exclusive use of in-person presentation by the researcher directly followed by distribution of the research questionnaires. As can be seen by Table 2, outreach efforts were primarily focused between the months of September 1992 through January 1993. Special emphasis was placed upon distributing the questionnaire to members of the five different borough Medicaid Advisory Councils; Manhattan; Brooklyn; the Bronx; Staten Island, and Queens. The questionnaires completed by members of the City-Wide Medicaid Advisory Council provided a very rich source of data. Fortuitously the administration of the questionnaire to the City-Wide Council occurred at the onset of outreach efforts. Based upon the valuable data obtained from the first Citywide Medicaid Advisory Council meeting, the researcher decided to emphasize the inclusion of the five borough-based Medicaid Advisory Councils in the study. This strategy represented a departure from the initial design for outreach since the initial plan was to only include advocates working with the elderly who practiced in Manhattan.

As indicated in Table 3 outreach efforts were focused on these Councils during the months of September, November, and January. In January 1993 four Medicaid Advisory Councils were attended by the researcher. This was the most concentrated outreach effort to this specific Council. Administrative factors influenced the concentrating of outreach during this month. For example, permission was needed from both the director of Public Relations at Medicaid, and then from the individual chairs of each borough council in order for the researcher to present on these Councils. Logistical problems were created because it took several months for permission to be obtained and to schedule a presentation on the agenda's of each meeting. As the borough wide councils did not meet each month, the most concentrated efforts occurred during January.

Administration of the questionnaire was also accomplished through in-person distribution at community-based meetings, inter-agency councils on aging, and other forums to which the researcher had access. Table 2 indicates the sequence of outreach efforts during the study. As indicated, a total of 24 presentations was made to recruit participants for the study. In addition to presentations at the Medicaid Advisory Council meetings, five presentations were at IAC's (inter-agency council meetings). The East Side Council on the Aging, the Murray Hill Interagency Council on Aging, the Manhattan Borough Wide Council on Aging, and the West Side Interagency Council on the Aging were the inter-agency councils where the study was presented. Two presentations were made to the East Side Council on the Aging and the Murray Hill Inter-agency Council on Aging because attendance had been especially low during the first presentations.

As reported earlier, the response rate from the IAC's was considerably lower than the response rate from the Medicaid Advisory Councils (31% as compared to 55% respectively). The lower response rate from the IAC's was attributed to the work experience of those attending the IAC's compared to those at the Medicaid Advisory Councils. Individuals attending the IAC's were involved in issues concerning the elderly in their work, but not all were involved in assisting their elderly clients in applying for Medicaid. In comparison, participants in the Medicaid Advisory Councils were considerably more experienced with Medicaid. For these advocates, Medicaid was a substantial part of their day to day practice. Issues related to access and coverage were primary concerns for these advocates. In addition, the data collected from such councils contrasted markedly with the rich data provided by the Medicaid Advisory Councils.

The response rate from other community-based agencies varied from a low of 20% from the Jewish Association for Services for the Aged (JASA), to a high of 100% from Search and Care (S&C). The low response rate from JASA was attributed to workers' lack of experience in assisting clients in application for Medicaid. Few workers at the Manhattan office had experience in helping clients apply for this entitlement. Those who did have experience, assisted very few clients on a yearly basis, on average less than three per year. Alternately, workers at Search and Care, a small community-based agency covering only a 10-block radius, had greater experience in helping their clients to apply for Medicaid.

The high response rate from S&C was attributed to the method of outreach employed at this

agency. All staff members completed the questionnaire while the researcher stood by and was available to answer questions. At the completion of this outreach session, all workers handed the completed questionnaire to the researcher. This model of outreach was replicated at two other sites--at the Burden Center on Aging (BCA) and at the Stanley Isaacs Center (SI). At the BCA the response rate was 83.33%; at SI the response rate was 66.66%. Replication of this model was only possible at these small community agencies, who were willing to have all staff participate at the presentation at the same time.

Another model of outreach which generated a high response rate was that used with the Social Work department at The New York Hospital (NYH). Copies of the questionnaire were given to the Director of Social Work, who then instructed her staff to complete the questionnaire, as soon as possible, and to mail it back. In this setting, the social workers from the hospital completed the questionnaire as an extension of their job expectation. With this model there was a response rate of 57%. The richness of individual response data obtained from this setting varied depending on worker experience. Some workers were very experienced, while others had not assisted any clients in the application process. Some NYH social workers said that they referred eligible clients to the Medicaid office of the hospital.

Outreach into the legal community was less productive on average than outreach into the social service community. Presentations were given at the New York Bar Association, and at the New York County Lawyers Association. In addition, an announcement was placed in the Elder Care News (see addendum), a newsletter for advocates in both law and social

services. The response rate from the legal community was lower than from the social service sector, which was somewhat surprising. It had been assumed by the researcher that because attorneys were now specializing in Medicaid "law" that the legal community would have been more responsive. As it turned out, the response rates from these two presentations yielded a response rate of 13% from the New York Bar Association, and a 20% from the New York County Lawyers Association. Although these attorneys provided consultation to individuals and their families regarding Medicaid law and eligibility, they typically referred Medicaid applicants to social service agencies and to private geriatric care managers for direct assistance with the application. Only seven of the attorneys who attended these two committees (there was some overlap in membership to both committees) actually assisted clients during the application process. There was only one response to the announcement placed in the Elder Care News, by an attorney who also served on the New York County Lawyer's Association. While the attorneys appeared interested in the study, few were actually experienced in the application process itself. Therefore, outreach into the legal community was considered less productive to the researcher.

Client Questionnaire

Clients who were interviewed were selected from the client case loads of the staff of Project SCOPE. Eight clients of Project SCOPE met the criteria of the study and were interviewed. Most client interviews were conducted in their own homes, with one client interviewed in the hospital. One client became fatigued during the interview, and a subsequent interview was

scheduled in order to complete the questionnaire. Most clients were able to supply the researcher very useful data. Unexpectedly, a few clients were not able to answer questions related to their application for Medicaid because someone else had applied for them. In those instances, the case manager or family members was contacted for completion of the questionnaire. Based upon these interviews, the role of the case manager in shielding the client from the bureaucratic process clearly emerged.

Selection of the Sample

Selection of Clients

As indicated above, in order to participate in this study, clients needed either to be in the process of applying for Medicaid, or to have received Medicaid approval within the past 12 months. Clients needed to be alert and oriented in order to answer the researcher's questions, and willing to participate in the study. Case managers of Project SCOPE were asked to submit the names of their clients who met these criteria. Out of a total case load of 225 clients, only 4% met the above criteria. While this finding in itself was unexpected, it is not wholly surprising, given the funding source's request that Project SCOPE prioritize its services for individuals who are not eligible for Medicaid.

Selection of Advocates

The study design required responses from a variety of social service and legal advocates for the elderly. The initial selection of respondents was based upon the following guidelines: individuals had to have experience in working with the elderly and experience helping them apply for Medicaid. In addition, advocates needed to be willing to complete the questionnaire. The most desirable respondents would be those able to provide in-depth information related to their experiences in applying for Medicaid. In order to reach a sample of respondents who matched the above criteria, it was necessary to reach out to a larger advocate population so that a sample of 75 would be obtained.

While it would have been possible to reach the target of at least 75 respondents through more conventional methods of data gathering (i.e., through the mail), it was decided that a more aggressive means of data gathering (i.e., through in-person presentations) would be more effective and efficient in reaching the target group and number in a shorter length of time. Criteria for selection of the sample were revised, as indicated above, following review of the initial questionnaires completed by members of the Citywide Medicaid Advisory Council. Review of these questionnaires indicated that individuals who served on the Medicaid Advisory Council were more experienced in assisting older people in applying for Medicaid. As a result of this information, selection of the target sample was revised to include as many Medicaid Advisory Council members as possible. Thus, outreach efforts were revised to prioritize Advisory Council members from the five boroughs, rather than outreach only into

the general advocate community as originally intended. This revision in sample selection proved to be profitable in providing rich in-depth data.

Respondent Profile

On the following pages, tables will be presented which will illustrate a description of the sample of advocate respondents. In addition, tables will be presented which illustrate the time frame of the outreach efforts, and the various types of outreach and their respective response rates.

Table 1 Profile of Advocate Respondents (N=102)

	Mean	Range	Median (Years)
age	39.8	22-85	36.5
years social service experience	10.6	0-37	7.0
years working with elderly	7.4	0-30	5.0

Description of Advocate Respondents

The response from advocates surpassed the initial target of 75 respondents. A total of 130 advocate questionnaires were returned to the researcher, and 102 were chosen to be included in the study (28 were not adequately completed).As indicated above in Table 1, the average age of respondents was 39.8 years of age. Respondents ranged in age from 22 to 85 years of

age. Seventy-seven of the respondents were female (75.5%), while only 25 males (24.5%) completed the questionnaire. This finding is not surprising considering the higher representation of females in the social services. The majority of respondents, eighty-three (81.4%) individuals, described themselves as Caucasian. Ten respondents (9.8%) described themselves as African Americans, six (5.9%) as Hispanic, one (1%) as belonging to the "other" category. Fifty-two (51%) respondents indicated that they had an MSW as their highest level of education completed. Twenty (19.6%) had a BA level degree. Seven (6.9%) respondents had completed their JD. Three completed a BSW, and two had a DSW degree. Twelve (11.9%) had other degrees including Master's degrees in Counseling, Sociology, Urban Affairs and Public Health. Three respondents indicated that a high school diploma was their highest level of education completed.

Respondents worked in a variety of settings including home care agencies, hospitals, and legal service organizations. The largest group of respondents, 24 (23.5%), indicated that they worked in a hospital or health care clinic. Twenty (19.6%) stated that they worked in public, not for profit, aging services, 18 (17.6%) described their place of work as a community-based organization. Eleven (10.8%) said they worked in private, for profit, aging services. Seven (6.9%) indicated they worked for a home care agency, while another seven (6.9%) said that they worked in a settlement house. Six (5.9%) indicated they worked in legal services, while the remaining nine (9.2%) worked in a variety of other settings including private practice, housing facilities and a nursing home. The majority (67.9%), indicated that they were primarily involved in direct practice. Twenty percent were involved in advocacy, 5 % in

supervision, 5 % in administration, and 3 % in other types of practice including case management and advocacy supervision. Respondents differed in regard to their experience in assisting Medicaid applicants. On average, respondents assisted 120 persons per year. The median number of applicants assisted per year was 20, while the mode was 10. The number of applications per year ranged from 0 to 2,446 per year. Surprisingly, at least 21 respondents said that they assisted 100 or more Medicaid applicants per year.

Table 2- Time Frame of Client and Community Outreach

Month/Year	Number of clients Interviewed	Number of Outreach Efforts
June 1992		1
July 1992	6	0
August 1992	2	1
September 1992		2
October 1992		7
November 1992		7
December 1992		2
January 1993		4
Total	8 clients	24 outreach efforts

Table 3- Response Rates of Outreach Efforts (listed in chronological order)

Forum	Number Distributed	Number Returned	Response Rate
MH-IAC	-0-	-0-	N/A
S&C	6	6	100.0
City MAC	28	15	53.6
Man. MAC	12	7	58.3
JASA	15	3	20.0
DFTA/CM	12	6	50.0
MH-IAC	11	5	45.5
ESCOTA-IAC	15	3	20.0
SSA	10	1	10.0
Burden Center	12	10	83.3
NYH	35	20	57.1
NASW OPC	14	2	14.3
BI North	3	2	66.7
Stanley Isaacs	3	2	66.7
Boro- IAC	18	5	27.8
NY Bar Assoc.	15	2	13.3
NY County Law.	8	2	25.0
ESCOTA-IAC	10	2	20.0
Queens MAC	13	11	84.6
DFTA-CM	2	1	50.0

Table 3 (Continued)

Westside-IAC	20	6	30.0
SI MAC	9	6	66.7
Citywide MAC	5	2	40.0
Brooklyn MAC	12	5	41.7
Bronx MAC	22	6	27.3
Total=	310	130	41.9% (Mean Rate)

Some of the forums in Table 3 are listed more than once (e.g., ESCOTA, Citywide MAC). These forums were utilized twice for outreach purposes because there were additional individuals who had not attended the forum during the first outreach effort. Because most of the above forums met monthly or bimonthly, some members were not able to attend every session. The second outreach to these forums helped to ensure that the maximum number of members was asked to participate in the study. Although a total of 130 questionnaires was returned to the researcher, they were not all utilized in the researcher's findings. Twenty eight questionnaires were not used because they were only partially completed, leaving important areas of the questionnaire unanswered.

In summary, the majority of the data collection was completed during a nine-month period of time, from July 1992 to February 1993. Interviews with clients took two months to complete, while obtaining advocate questionnaires took over six months. The next chapters discuss the findings from the questionnaires from advocates (Chapters 4 and 5), and the findings from the client interviews will be presented in Chapter 7.

Chapter 4

Findings: Advocate Responses

Introduction

Analysis of findings from the Advocate Questionnaires will be presented in the following chapter. A total of 102 social workers and other advocates for the aged responded to the Advocate Questionnaire (see the addendum). A detailed description and analysis of their responses will be presented. Advocates were asked to indicate what they considered were obstacles to accessing Medicaid for their clients. Advocates identified obstacles which were primarily attributed to the organizational structure of the Medicaid Administration. Several client-based variables were also found to create perceived barriers to coverage.

Clients Served by Respondents' Agencies

Respondents indicated that the majority (70.9%) of the clients served by their agencies were female. Almost two-thirds (64.4%) of the clients served by respondents' agencies were

Caucasian. Nineteen percent (18.8%) were African American. Hispanic clients represented 14.5% of those served. Asian clients were in the smallest proportion of the clients served, representing only 2.6%. Another 3.3% of the clients served belonged to the "other" category, comprising Indian and other individuals from various countries of origin. English was the native language of 70.5% of clients served. Approximately 12% (12.6%) were native Spanish speaking. Chinese was the first language of 2% (2.1%) of the clients served. Another 8.7% had various primary languages including, Greek, Hungarian, German, Italian, French, Hindi, Hebrew, Yiddish, Russian, Polish, Portuguese, Polish, and Norwegian (6.1% was not reported).

Difficulties Accessing Medicaid Coverage

It was hypothesized that most advocates would indicate that they experienced difficulty accessing Medicaid coverage for their clients, and that these difficulties would be influenced by both client and organizational factors. Analysis of a sample of 102 advocates confirmed this initial hypothesis. The findings indicate that almost three-quarters (72.5%) (see Table 4) of the advocate respondents said that they encountered difficulties in accessing Medicaid for their clients more than one half the time (51.3%).

Table 4-Difficulties Accessing Medicaid Coverage (N=102)

Difficulty Experienced	Percentage of Frequency
Yes	72.5%
No	23.5%
Not Answered	4 %

This finding further affirms the practice value of identifying the specific obstacles experienced when accessing Medicaid. Identifying these obstacles and outlining effective strategies to overcome them will help facilitate greater access to Medicaid. Analysis of these specific obstacles will be presented in this chapter. The strategies recommended by advocates will be described in Chapter 6.

Time Duration For Accessing Medicaid Coverage

One anticipated difficulty in accessing Medicaid was the lengthy time duration from initial application to the date of approval. While Federal Medicaid regulations mandate that a determination of eligibility must be made within 30 days, it was hypothesized that it took the average practitioner longer to get Medicaid for their clients. Research findings confirmed this hypothesis. Data analysis indicated that it took an average of 2.25 months (67.73 days) for advocates to get their elderly clients Medicaid coverage (see Table 5). Almost 84% indicated that Medicaid decisions took longer than 30 days to be reached. Forty-four percent of the sample indicated that Medicaid approval usually took longer than two months (see Table 6).

Based upon findings from this sample, the researcher concludes the Medicaid administration is out of compliance with respect to the mandated time frame of 30 days for eligibility determinations.

Time Duration for Medicaid-Funded Home Care Services

The majority of community dwelling elderly apply for Medicaid in order to receive Medicaid-funded home care services. Determinations for Medicaid and Medicaid-funded home care are often made in tandem with each other. Findings indicate that it took advocates an average of 2.63 months (79.1 days) to obtain Medicaid-funded home care services for their elderly clients (see Table 5). Only 13.7% of advocates said that a determination was made within 30 days. Almost thirty-seven (36.9%) said that a determination was usually made between 31 and 60 days. Forty-nine percent (49.3%) said a determination usually took longer than two months to be made.

Table 5-Mean Time Durations for Obtaining Medicaid and Medicaid Funded Home Care

Type of Coverage	Mean (days)	Standard Deviation	Number Cases
Medicaid (MA)	67.7	40.9	86
MA Home Care	79.1	52.5	73

Table 6-Percentage Distributions for Obtaining Medicaid and Medicaid Funded Home Care

Time Duration (days)	Medicaid Coverage (N=86)	Medicaid Home Care (N=73)
<30	18.6%	13.7%
31-60	37.2%	36.9%
>61	44.2%	49.3%

High Volume Advocates

Only 18.6.9% of the advocates who responded said that they were able to get coverage within one month. Those who were able to obtain Medicaid for their clients within 30 days tended on average to be those who processed larger volumes of Medicaid applications (range 100-2446). Respondents who were able to obtain approval for home care services within 30 days also appeared to be involved with the processing of large volumes of Medicaid applications per year. In addition, advocates who were involved with large numbers of Medicaid applications were found to have less difficulty accessing both Medicaid and Medicaid funded home care for their clients. When they experienced difficulty, it was in smaller proportion than their professional colleagues who handled a lower volume of applications. Such findings suggest that this small (21 individuals), but practically significant, segment of the respondent sample may be more efficient in processing applications than the majority of respondents.

Greater exploration into this subset of advocates may reveal valuable recommendations for practice. An analysis of the relationship between number of applications per year and difficulties accessing coverage will be explored in greater depth in Chapter 5.

Amount of Respondents' Time Assisting Applicants

On average, advocate respondents indicated that they spent more than one work day (8.86 hours) each week assisting clients to obtain Medicaid (see Table 7). Three individuals indicated that they worked full-time (35 hours/week) assisting applicants. The majority (78.4%) spent between one-half hour and 11 hours per week on tasks related to accessing Medicaid for their elderly clients. Almost one-half (49.5%), said that they spent between one-half and five hours each week, 28.9% said they spent between 6-11 hours a week, and 8.2% said they spent between 12-17 hours a week assisting Medicaid applicants.

Table 7-Percent Distribution of Respondents' Time Spent Assisting Applicants

Hours/week	Percentage of Respondents
.5-5	49.5%
6-11	28.9%
12-17	8.2%
35	2.9%
Missing	10.5%
Total	100%

(Mean=8.86 hours, Mode=2 hours, Median=6 hours)

Respondents were asked to provide a breakdown of how they spent their time when assisting applicants. As indicated by Table 8, advocates spent the largest average time per week in telephone contact with CASA (3.79 hours), followed next by the amount of time they spent in written correspondence with CASA (3.42 hours). Respondents spent the least amount of time (2.39 hours) encouraging eligible clients to apply for Medicaid. Advocates also spent considerable time helping clients and their families gather documentation (2.99 hours) and then photocopying these documents (2.93 hours).

Table 8-Respondents Time Spent Assisting Applicants (hours/week)

Type of Activity	Mean hours per week
Counseling Eligible Clients	2.39
Telephone contact with clients	2.73
Photocopying	2.93
Gathering Documentation	2.99
Written Correspondence with CASA	3.42
Telephone contact with CASA	3.79

Advocates also provided a listing, but no time estimates of other activities which were related to assisting applicants not mentioned above. These activities included: orienting clients on Medicaid procedures, the surplus program, transfers of assets, the spend-down process, and Medicaid estate planning.

Client-based Obstacles to Medicaid

To determine if certain client-based factors played a role in influencing access to Medicaid, an analysis of the relationship between client characteristics and perceptions of Medicaid accessibility was conducted. A limited pretest study of Project SCOPE clients suggested that older female applicants may have a more difficult time accessing coverage than their male counterparts. Based upon this limited study the researcher assumed that traditional societal roles of women as home makers, not financial managers, may leave older female applicants less equipped to confront the numerous demands of the financial documentation for Medicaid. Analysis of respondent data refutes this assumption. Although female clients represented the majority (70.9%) of clients served by advocate respondents, gender was not found to play a major role in determining their access to Medicaid coverage. According to advocate report, eighty-four percent (84.3%) of respondents did not think that gender played a part in determining their clients' ability to obtain Medicaid coverage. Only 10.8% said they noticed gender-based differences in their clients' ability to obtain Medicaid access.

When respondents were asked whether older male or older female clients had an "easier time" accessing coverage, the majority (79.4%) said that they found no difference. Respondents who did indicate gender-based differences, tended to provide stereotyped explanations for those differences. Almost 6% (5.9%) said that they thought that older women, in fact, had an easier time obtaining access. For example, one advocate wrote, "older women have an easier time. They generally have less retirement income than older men, qualifying is therefore

easier for them."

In contrast, almost 4% (3.9%) indicated that they thought that older men had an easier time obtaining access. Another respondent stated, "older men have an easier time. They are less fearful, and more assertive. Older women tend to be more intimidated by the bureaucracy than their male counterparts, due to the fact that their spouses probably handled family finances and other planning issues. " Alternatively, many older women are more assertive than their male counterparts, especially in interactions with medical and social service providers. Close to 11% (10.8%) of the sample did not respond to this question.

Why Eligible Clients Don't Apply?

The researcher wanted to explore other client variables which may influence the reluctance of some older women to apply for Medicaid (even through they were eligible and could benefit from its coverage). Respondents were presented with a listing of reasons why Medicaid eligible clients did not apply. The goal was to identify, from the practitioner's perspective, some of the client-based obstacles to application. Based upon their practice experience, advocate respondents were asked to rank order (1=most frequent, 4=least frequent) a series of possible reasons that Medicaid eligible women did not apply.

The stigma associated with Medicaid was indicated by advocates as the primary reason most eligible women did not apply (rank order of 1.9, see Table 9). The second most common

reason was because of the difficulties that clients' friends and neighbors reported with the Medicaid administration (rank order of 2.56). In contrast with Schultz (1984), the need to disclose full financial information during the application process was ranked lowest in frequency (rank order of 2.68). Other reasons, including a lack of basic understanding of Medicaid's benefits, on the part of eligible clients, were equally ranked with financial disclosure.

Table 9-Rank Order of Reasons Eligible Women do not Apply for Medicaid

Frequency Rank Order	Reason
1.9	Stigma Associated with Medicaid
2.56	Difficulties of Friends/Neighbors
2.68	Need for Full Financial Disclosure
2.68	Other Reasons

These findings suggest that the fear of a stigma, not of financial disclosure, may deter most eligible older clients from applying for this valuable entitlement. This finding is consistent with those of Alexander & Podair (1969), and Estes, et al. (1984). Application of these findings to practice will be presented in the final chapter.

Lack of Accurate Financial Information

Difficulty obtaining accurate financial information from applicants was found to create an another client-based obstacle to securing Medicaid coverage. A large proportion of advocates

indicated that they frequently encountered problems obtaining adequate financial information from clients. Almost 64% (63.7%) of respondents indicated that a lack of accurate financial information created an obstacle to accessing coverage. Advocates indicated that lack of accurate financial information occurred an average of 31% of the time (see Table 10).

Table 10-Obstacles Encountered by All Respondents During the Application Process

Obstacles	Percentage of Cases	Frequency Occurrence
Tracking	59.8	58.5
Inaccurate Fin.	63.7	29.9
Documentation	78.4	43.2
Duplicate Doc.	54.9	32

Medicaid: The Application Process

In addition to client-based obstacles, the researcher wanted to identify the points in the application process where client advocates experienced the most difficulty. Identification of these specific obstacles would help determine strategies for overcoming them. Practitioners were asked to identify the points in the application process at which their clients experienced the most difficulties or barriers.

Specific Obstacles Encountered

Respondents were asked to identify the types and frequencies of obstacles they encountered during the application process. Difficulties tracking the progress of a Medicaid application after submission to Medicaid, lack of accurate financial information from clients, difficulty obtaining documentation from clients, and multiple requests for client information from CASA/MA were among the primary obstacles advocates were asked to identify. Respondents were also asked to indicate any other obstacles they encountered during the application process.

Documentation

Difficulty obtaining documentation from clients was found to be the most frequently encountered obstacle for advocates. Over three-quarters (78.4%) said that they encountered difficulty obtaining necessary documentation for or from their clients. On average, advocates experienced difficulty getting documentation from clients 43.2% of the time (see Table 10). Difficulty securing adequate documentation may be attributed, in part, to the vast amount of documentation needed for the application--at least 10 items are needed at the minimum (see Addendum) combined with time constraints for submitting this documentation. For example, one advocate described the difficulties her clients experienced obtaining documentation while awaiting approval for Medicaid funded home care: "For the community applications, the clients have the most difficulties in preparing documentation. With home care cases, the

problem rests in securing the documentation while maintaining an active M11Q [home care assessment form] for the Medicaid application. Frequently the M11Q expires before the application for Medicaid is completed."

Documentation for home care services was also mentioned by another respondent as a problem for some of his clients. "Obtaining an M11Q is very difficult for clients whose primary physician is a clinic doctor, quite common among Medicaid eligible patients. Other doctors are unwilling to complete the M11Q because they do not know the client."

In addition, some of the other documents needed, i.e., birth certificates, may be very difficult to locate or obtain for an older person. Therefore, the obstacles encountered in documentation may be attributed, in part, to the large number of required documents in combination with client and organizational variables.

Repeated Requests for Documentation

Almost fifty-five percent (54.9%) of respondents indicated that they experienced repeated requests for client documentation from Medicaid. Advocates stated they were asked to submit the same client documentation at least twice 32% of the time because the originals could not be located by the CASA worker or Medicaid representative. Wrote one advocate, "applications are held for as long as six months with repeated requests for documentation without clear instructions. For example, a transfer [of assets] must include a photo copy of

bank account the money was withdrawn from and bank account into which the transferred money was deposited. Many case workers do not explain this to applicants who repeatedly submit copies of the closed account only."

Difficulties Tracking

Difficulty tracking the progress of the application once it was submitted to Medicaid was another obstacle identified by advocates. Trouble tracking the application after submission was experienced by almost 60% of respondents. Respondents encountered difficulty tracking an average of 59% of the time.

Organizational Obstacles Identified by Advocates

In addition to the above obstacles which were included in the Advocate Questionnaire, respondents identified other obstacles they encountered while assisting their elderly applicants. Advocates described a number of organizationally-based obstacles, attributed to the Medicaid Administration: a lack of knowledge about Medicaid guidelines, procedures, and policies on the part of Medicaid personnel, and problems attributed to Medicaid's organizational structure. To follow will be a discussion of these obstacles. When possible, advocate statements will be included to illustrate.

Obstacles Related to the Medicaid Administration

Lack of Adequate Training on Medicaid Guidelines

Advocates consistently stated they experienced difficulty accessing coverage for their clients because of what they considered to be a lack of adequate knowledge of policies and procedures on the part of Medicaid personnel. For example, one advocate stated that, "ignorance of Medicaid rules by Medicaid staff resulted in numerous problems. Some are still unaware of the transfer of assets law." Another advocate wrote, [there is] "gross misinformation given to applicants" [by Medicaid personnel]. Still another advocate stated, "there is a complete lack of knowledge by caseworkers on eligibility criteria. Case workers do not receive adequate training nor do they receive support in advocating for clients."

In addition to a general lack of knowledge about eligibility, some advocates indicated that Medicaid personnel made incorrect determinations and other mistakes which created additional obstacles to access. One respondent wrote, "Medicaid makes a determination which runs counter to the documentation submitted. I have found that Medicaid consistently makes incorrect determinations, 100% of the time. Workers usually give the wrong information to clients."

Another advocate stated, "one of my cases was found eligible, but her application was then misplaced, resulting in her going into debt to pay for private home care. The [Medicaid]

system presents mixed reasons for ineligibility, contrary assessments, differential loopholes, tie-ups and any other reason possible for denying coverage."

Respondent statements reflect a lack of consistent training of Medicaid personnel regarding eligibility guidelines and policies, resulting in increased barriers to access for applicants. Findings suggest the need for greater, more comprehensive training for workers involved in the processing of Medicaid applicants.

Medicaid's Organizational Structure

Advocates also mentioned obstacles which appeared related to the structural design and organizational dynamics of the Medicaid Administration. Difficulties contacting caseworkers, lack of adequate staffing, high caseload size, and poor work related attitudes were reported by advocates as additional factors which appeared to create obstacles to coverage for their clients. To follow will be brief excerpts from advocate responses illustrating these problems.

Difficulty Accessing Medicaid Staff

One advocate described the difficulty she encountered in making contact with Medicaid staff during the application process: "I have difficulties tracking down caseworkers to inquire about the status of my client's case." Another advocate wrote that she experienced an "inability to make telephone contact with Medicaid. I have difficulty advocating for the client,

trouble tracking down the worker, supervisor and other Medicaid personnel. Telephone lines are constantly busy or they keep ringing and no one ever picks up."

A female respondent stated, "intensive advocacy and follow up is required to ensure smoother access to services. There are numerous pitfalls in the system--things get lost unless certified mail is sent. Sometimes papers have to be faxed and re-faxed. CASA [the home care division of Medicaid] is reluctant to give us direct access to our Medicaid section, and equally reluctant to follow up for us instead. The system plods along slowly without any intervention."

Lack of Adequate Staffing

Lack of adequate staffing combined with inadequate training and poor work related attitudes were mentioned by advocates as organizational obstacles they frequently encountered in accessing coverage."Short staffing of the Department of Social Services is a problem. They are unavailable for questions. There is high tension between overworked caseworkers and fearful or angry clients. Much advocacy and mediation are needed," wrote one advocate.

Stated another advocate, "CASA/Medicaid workers appear overworked, overwhelmed and often angry at their work situation. They often complain of being understaffed. Phone calls to them are seen as intrusive. Messages left are rarely returned. Supervisory staff is not available. There is a lack of staff and too many cases. Workers are always rushing. They have

no time to listen to clients."

Poor Work-Related Attitudes

Respondents suggested that Medicaid staff frequently lacked a positive helpful attitude toward their clients. According to one advocate's report, [there is an] "unwillingness of Medicaid personnel to be of assistance without pressure from Human Resources Administration officials. Workers are not responsive to clients. They refuse to give things clients are entitled to, even a letter stating the client has applied. They refuse to help gather documentation, no Xerox, no FAX, and withhold such options as interim care, even when appropriate."

Medicaid System: Non-responsive to the Needs of Older Persons

Analyses of advocate statements further suggest they consider the Medicaid system unresponsive to the needs of physically or cognitively impaired older applicants. Wrote one advocate, "most of my older clients have some form of mental illness and the system makes it difficult for this kind of client to access services. They require an advocate [to assist them]. Despite repeated requests with caseworkers to contact me, they never do so. Also, Medicaid workers have little respect for homebound clients' time. They often do not keep appointments, or bother calling to say when they will be coming." In addition, wrote another advocate, "access and assistance for those who can't ambulate is limited."

Assistance Received From CASA/Medicaid

It was hypothesized that practitioners would indicate they found the assistance they and their clients received from CASA/Medicaid not especially helpful. As indicated in Table 11 , analysis of respondent data suggests that this hypothesis was not confirmed. In fact, almost two-thirds (65.1%) described CASA/Medicaid's assistance as either very helpful (7%), helpful (33.7%), or neutral (26.4%). Only one third (34.9%) described this assistance as not helpful. Nonetheless, the qualitative responses from those respondents who found CASA/Medicaid's assistance "not helpful" were especially rich and elaborate, in contrast with those who described their assistance as "very helpful," "helpful" or "neutral." To follow will be selections of excerpts from respondents' statements to illustrate each descriptive category.

Table 11-Respondents' Description of Assistance Received from CASA

Degree of Helpfulness	Percentage	Valid Percentage	Cumulative Percentage
Very Helpful	5.9	7.0	7.0
Helpful	28.4	33.7	40.7
Neutral	20.6	24.4	65.1
Not Helpful	29.4	34.9	100%
Missing	15.7		
Total	100%	100%	

Very Helpful Responses

As mentioned above, 7% of respondents indicated that they thought that CASA/Medicaid's assistance was very helpful. Wrote one of these respondents, "I work with a special cluster-care home care program and the CASA worker is very supportive and efficient." A different respondent described how the services of Medicaid and CASA were very helpful to her clients. "Without Medicaid, many clients could not possibly afford adequate medical or dental care, nor be able to get medication and medical services."

Helpful Responses

Over one-third (33.7%) indicated that they thought the assistance they received was helpful. To follow is an excerpt from one of their statements. "Most of our clients go to _____ Hospital's Medicaid office. Their applications are reviewed and processed. When I need information on the client's application, the information is usually supplied through the hospital's office." Stated another advocate, "in light of the size of the system there are some staffs that work under adverse conditions, and still manage to do a good job."

Neutral or Contingent Responses

Over one-quarter (26.4%) said they considered the assistance their clients received was neutral, meaning their assistance was neither helpful nor harmful. When answering this

question, most respondents said their experience was variable, and that for the most part it depended upon the individual CASA/Medicaid worker or the office that handled the application. For example, one respondent wrote, "Very much depends on the case worker, on the case and the supervisor. Some CASA workers are organized, persistent and helpful (rare!). The majority were overworked, vague, disorganized and obstructionary--requesting duplicate documents, being evasive, not returning calls."

Another respondent also indicated that her experience varied, "it depends on the particular office--some Medicaid supervisors are more helpful than others. Basically, I think clients receive confusing, very poorly explained letters (sometimes disturbing phone calls) regarding their application, and requests for more information (deferrals). I think if these clients didn't have social workers helping them they would simply give up and never receive the coverage for which they are eligible."

"This is hard to answer," wrote another advocate. "I think a lot of the assistance depends upon the case worker. I've had problems with different case workers, but it seems like some are more willing than others to work for the clients. Once the assistance is in place everything seems to go smoothly until the re-certification process comes up--then it can start all over again! It really depends on the case worker from CASA. Some are extremely helpful and resourceful, others will drop the case on a whim and not even notify me."

Not Helpful Responses

Over one-third (34.9%) of the respondent sample, described the assistance they and their clients received from CASA and Medicaid as "not helpful." This group represented the largest single group of respondents. They indicated that interacting with representatives from the Medicaid administration actually made "things worse" for their clients. Advocate respondents who answered this question provided the researcher with the most descriptive qualitative responses of all groups. For example, wrote one respondent, "intake workers are not helpful--[their] attitude is how can we keep people off of Medicaid. Also intake workers lack adequate training on what the [Medicaid] regulations say and how to apply them. Usually a different answer is given to the same question--depending on whom you ask. Applications languish on desks. There is a tendency for CASA to close a case without notifying me or the client beforehand about the reason for denial. [There is an] unwillingness to work for [the] client. They tend to work against the client."

According to one respondent it has become more difficult for CASA workers to assist clients following staffing changes at their office: "Apparently when the CASA III workers submit applications to their Medicaid people, all control and follow-up seems to be lost. CASA III workers report that their Medicaid section is particularly hostile to their inquiries and indifferent to their requests for timely processing. The removal of the Medicaid section staff from the CASA Director's direct supervision was a disastrous step backward. Workers are

often angry, rude, and punitive."

The tactics used by CASA workers were described by another advocate as misleading and prolonging the application process: "The CASA workers fail to assist the client in gathering the necessary documentation. They make vague requests for documentation, misleading clients into thinking their initial submissions are sufficient. This sloppy interaction with clients not only confuses them but often frustrates them and lengthens the process. This makes things worse by allowing the M11Q to expire and necessitating another."

"Unfortunately, my experience with workers in the Medicaid office has been mostly negative," stated another respondent. "They treat applicants poorly and many clients have terminated the application process after the initial interview. The clients' often report feeling demeaned and humiliated. Medicaid office workers (local offices) need supervision and appear to be poorly supervised. I have smelled alcohol on the breath of one worker at 9:30 AM on several occasions."

Conclusion and Summation

In summary, the majority of advocates experienced difficulties in their efforts to obtain Medicaid for their elderly clients. Difficulties were attributed, in part, to problems obtaining sufficient documentation from older clients for the application, difficulty tracking down individual workers, and following the progress of the application. Advocates described what

they viewed as inadequate knowledge on policies and regulations, as well as poor work-related attitudes on the part of some Medicaid personnel. The perceived helpfulness of Medicaid staff varied, and depended, in part, on the individual worker or office processing the application.

Nonetheless, approximately one-quarter (23.5%) of respondents indicated they experienced no difficulty accessing coverage for their clients. Those who did not experience difficulties tended, on average, to process higher volumes of Medicaid applications per year (at least 100). This finding suggests further investigation into those high volume respondents. An in-depth analysis of these respondents will be presented in Chapter 5.

Chapter 5

High Volume Advocates

Introduction

As indicated in the previous chapter, findings indicated that almost one-quarter of the advocate sample did not experience any significant difficulty in their ability to access Medicaid for their clients. Those who were found to have little or no difficulty accessing Medicaid, for the most part, were individuals involved in a high volume (100 or more) of Medicaid applications per year. Twenty one advocates from the larger advocate sample were found to process at least 100 applications a year. Analysis of findings from this segment of the advocate group will be presented in this chapter.

Comparison of High and Low Volume Advocates

The twenty one high volume advocates studied indicated that they processed between 100 and 2446 Medicaid applications per year (see Table 12). In two practically significant ways, these advocates differed from the larger sample of advocates: on average, these

advocates experienced less difficulty obtaining Medicaid for their clients; and they were able to do obtain Medicaid approval for their clients much faster than their professional counterparts.

Although high volume advocates did experience some difficulty accessing Medicaid for their clients, they were experienced less frequently than low volume advocates (less than 100 applicants per year). A t-test for significance was conducted to compare the two groups of advocates. Findings identified a statistically significant ($t=1.81$, $p<.04$) difference between the two groups in regard to overall difficulty accessing Medicaid (see Table 14). These findings indicated that the low volume advocate group experienced difficulty accessing Medicaid more than half the time (54.8%), while high volume advocates experienced difficulty significantly less often (39.5%). Findings also indicated that the average length of time for obtaining Medicaid approval for these advocates was significantly less ($t=-2.01$, $p<.03$) than for lower volume advocates (see Table 13). On average, high volume advocates were able to secure Medicaid access for their clients within 51.3 days compared to 72.3 days for all advocates. The average length of time for obtaining home care approval was shorter also. High volume advocates were able to obtain Medicaid funded home care within 61.35 days compared to 83.30 days for lower volume advocates. While this difference was not found to be statistically significant, it does have practical significance for advocates and recipients. To follow is a presentation of these findings.

Table 12 Profile of High Volume Advocates

Applications/yr.	Yrs. Experience	Work Site	% Difficulty
2446	14	Hospital	5%
1300	7	Legal Practice	0
1200	9	Hospital	0
750	15	Com. Based Org.	25%
700	21	Home Care	33%
700	1	Hospital	3%
500	7	Hospital	25%
400	2	Hospital	3%
350	21	Home Care	25%
300	8	Aging Services	0
200	5	Hospital	25%
175	37	Home Care	75%
150	18	Residential Care	2%
125	16	Hospital	1%
120	4	Hospital	25%
120	6	Home Care	85%
100	17	Com. Based Org.	5%
100	19	Legal Practice	4%
100	0.5	Mental Health	75%
100	0.5	Hospital	70%
100	18	Hospital	7%
Mean=477.9/yr.	10.8 yrs.		36.5%

Table 13-Comparison of High and Low Volume Advocates: Time Duration for Medicaid

	Mean Time (days)	t-value	p-level*
High Volume	51.3	-2.01	.023
Low Volume	72.3		

*for one-tailed test

Analysis of High Volume Respondents

Analysis of specific variables of the high volume advocates focused upon number of years of work experience, place of practice, length of time for obtaining both Medicaid and Medicaid funded home care, and analysis of difficulties in accessing Medicaid. In addition, the use of pre-screening training, Fair Hearings, and the helpfulness of CASA/Medicaid personnel have been analyzed for this segment of the advocate sample. Three high volume advocates and their specific access strategies will also be described in this chapter. Other specific strategies recommended by this subgroup will be included in Chapter 6 (Strategies Recommended by Advocates).

Years of Experience and Site of Practice

Advocates who were included in the high volume group were found to have slightly more years of work related experience than those in the overall sample group. The average number of years of work experience for the high volume advocates was 10.84 years

(range =.5 -37 years), as compared to 10.5 years (range=0-35 years) for the lower volume advocate group. Of the 21 advocates in the high volume segment of the sample, hospital-based practitioners were the most highly represented (ten individuals), followed by home care agencies (four individuals). Other work sites of practice included, community-based organizations (three individuals), elder care law practice (two individuals), mental health (one individual), and residential care (one individual), see Table 12.

The high volume hospital-based respondents tended to have an overall lower rate of difficulty than all other respondents. On average, hospital-based respondents experienced difficulties only 21.4% of the time, compared to 38.9% for high volume advocates in other sites of practice. In contrast, high volume advocates who worked in home care and mental health settings tended to have a higher percentage of difficulties than their hospital-based colleagues. For example, respondents in home care and mental health settings experienced difficulties accessing Medicaid for their clients, an average of 80% of the time.

Difficulty Accessing Medicaid for High Volume Advocates

Although high volume advocates were found to experience some difficulty accessing Medicaid, difficulties were experienced a smaller percentage of the time compared to the low volume advocate group. On average, high volume advocates experienced difficulties accessing Medicaid for their clients 39.5% of the time, compared to 54.8% of the time for low volume advocates. Advocates who processed the most applications per year (see

Table 12) were found to experience the least difficulty doing so. Interestingly, three of these high volume respondents indicated that they never experienced difficulty accessing Medicaid for their clients. The advocate who processed the most applications per year (2446) indicated that she experienced difficulties only 5% of the time.

Analysis of specific difficulties indicates that most high volume advocates experience some degree of difficulty accessing Medicaid for their clients. Twelve out of 21 high volume advocates stated that they experienced difficulty tracking the application after submission to Medicaid (see Table 14). High volume advocates, who experienced difficulty in tracking, experienced problems more than half the time (58 %) on average. High volume advocates stated they had trouble obtaining documentation from clients an average of 44.2% of the time. Requests for duplicate documentation were experienced by one-half of the high volume advocates. These high volume advocates were asked to submit duplicate documentation an average of 26.5% of the time. Sixteen out of 21 high volume advocates indicated they experienced difficulty obtaining accurate financial information from clients over one-quarter (27.2%) of the time. As suggested by these findings, within each category of difficulty, some high volume advocates experienced no difficulty at all. In almost all categories of difficulty (except documentation), the high volume group experienced lower percentages of occurrence compared to the low volume advocate group.

Table 14-Comparison of High and Low Volume Respondents: Percentage Occurrence of Specific Difficulties

Type Difficulty	High Volume	Low Volume	t-value	p-level*
Tracking	58 %	59.1%		
Documentation	44.2%	42.2%		
Dup.Document	26.5%	37.5%		
Inaccurate Fin.	27.2%	32.6%		
Overall Percent Difficulty	39.5%	54.8%	1.81	.037

*for one-tailed test

Other Difficulties Experienced by High Volume Respondents

In addition to the above difficulties, several high volume respondents described other difficulties they experienced when accessing Medicaid. The difficulties they experienced included a lack of helpful cooperation from Medicaid personnel and problems obtaining specific documentation for older women. According to one advocate, "People who work at Medicaid tend to be nasty, seem to take a lot of breaks or are out on vacation, or just seem unknowledgeable, or they do not want to do any work."

A different high volume respondent described difficulties he experienced obtaining documentation, "I have encountered difficulty obtaining Social Security numbers for some women, because they have always used their husband's number. It is also difficult to prove

that an older woman isn't getting a pension, as well as the need to prove joint bank accounts are really children's money [and not the applicant's]. I have found that many banks are uncooperative in supplying financial records."

Amount of High Volume Respondent's Time Assisting Applicants

As would be expected, the high volume advocates spent considerably more time per week assisting Medicaid applicants than was found in the larger low volume group. For example, high volume advocates spent approximately 19 hours (18.85 hrs) per week on average assisting Medicaid applicants, compared to an average of 8.86 hours for advocates in the larger low volume group. The range was between five and 35 hours, the median was 18.50 hours, and the mode was 25 hours.

Assistance Received From CASA/Medicaid

Findings from the high volume sample were fairly consistent with those of the larger sample group in evaluation of the assistance they and their clients received from CASA/Medicaid. More than two-thirds (68.4%) of high volume advocates described the assistance their clients received from CASA/Medicaid as either neutral (26.3%) or not helpful (42.1%). Almost one-third (31.6%) found CASA/Medicaid's assistance to be helpful. In contrast with the larger sample group, none of the high volume advocates found CASA/Medicaid's assistance to be very helpful. One high volume advocate did not

respond to this question because she was not directly involved with working with CASA/Medicaid, (she prepared all the paper work, which was then processed through a separate office of her hospital).

Medicaid Fair Hearings and Conferences

Sixty-five percent of the high volume advocates indicated that they requested Medicaid Fair Hearings to protest ineligibility determinations by Medicaid. In contrast to the larger advocate group, of which three-quarters (75.6%) went to Fair Hearings, a smaller proportion of high volume advocates went to Medicaid Fair Hearings. However, those high volume advocates who did request Medicaid Fair Hearings, did so more frequently. On average, high volume advocates requested Medicaid Fair Hearings an average of 14.6 times per year (range= 0-100), compared to an average of 12.2 times a year (range=1-253) for low volume advocates.

Fair Hearings for Service Authorizations

A smaller proportion of the high volume advocates requested Fair Hearings to protest service authorizations for home care. However, high volume advocates who requested Fair Hearings because of service authorizations, requested them more frequently than eligibility Fair Hearings. Seven out of twenty one high volume advocates (35%) indicated that they requested Fair Hearings because of service authorizations. On average, high

volume advocates requested Fair Hearings for service authorizations 31 times a year (range=0-150), compared to 12.2 times a year for eligibility determinations. In comparison with other advocates, a smaller proportion of high volume advocates requested service authorization Fair Hearings (35% compared to 77.8%), but those high volume advocates who requested Hearings did so more frequently than did all advocates, an average of 31 times a year, compared to 5.74 times a year, respectively.

Conferences

Findings indicate that a slightly higher percentage of high volume advocates requested Medicaid Conferences. High volume advocates requested Medicaid Conferences more often than the overall advocate group. Thirty-three percent of high volume advocates (seven out of 21 individuals) requested Medicaid Conferences to help resolve difficulties in accessing Medicaid for their clients, an average of 12.7 times a year (range 0-80), compared to one-third of the larger advocate group who requested Conferences an average of 5.22 times a year (range=1-80).

Utilization of Pre-screening Training by High Volume Advocates

Pre-screening training was utilized in higher proportion among the high volume advocates, than was found in the larger advocate sample. Thirteen out of twenty one (62%) high volume advocates had been trained as pre-screeners by Medicaid, compared to 36.3% of

the overall advocate group. High volume advocates, who had been trained as pre-screeners, indicated that they found the training either helpful (46.1%) or very helpful (53.8%) in assisting them to access Medicaid for their clients. The high volume advocates who were trained as pre-screeners overwhelmingly (84.6%) indicated that they thought that this training had helped them give their clients faster access to Medicaid, compared to 73.4% for all other advocates. Eleven out of thirteen high volume advocates used their pre-screening training to schedule appointments for Medicaid applicants.

Descriptions of Several High Volume Advocates

Three high volume advocates will be presented to provide an illustration of their background and work situations. The specific strategies recommended by these professionals will also be presented. The advocate who processed the highest average of applications a year (Ms. A) will be presented first, followed by the next two highest volume advocates (Mr. B and Ms. C).

Ms. A. is a 45-year-old Caucasian female, who holds a M.S.W. degree and has 14 years of experience working with the aged. At the time of the survey, Ms. A. was working in a hospital/health care clinic as a program coordinator. The primary function of her position was to provide supervision to the clinic. On average, Ms. A. said she assisted 2446 Medicaid applicants per year. This was the highest number of Medicaid applications processed by any single respondent. Fifty percent of her clients were female.

Ms. A. experienced difficulties accessing Medicaid coverage for her clients only 5% of the time. When she encountered obstacles, they were in relationship to obtaining accurate financial information from clients prior to application (20% of the time) and difficulties obtaining documentation from clients (20% of the time). In her opinion, the assistance her clients received from CASA/Medicaid was neutral. She explained, "We prepare the Medicaid application and documentation and then submit it to CASA with the M11Q."

On average, she attended 12 Medicaid Fair Hearings a year to protest eligibility determinations, and 1 Fair Hearing a year because of home care service authorizations. In addition, she went to two Medicaid conferences in the year preceding the study. On average, it took her less than one month to obtain Medicaid approval for her elderly clients, (two months for her clients under 65), and between two and three months to obtain Medicaid funded home care services for her older clients.

Like most high volume advocates, Ms A. was trained as a Medicaid pre-screener and scheduled Medicaid application appointments for her clients. She also indicated that she found the pre-screening appointment very helpful in facilitating access to Medicaid for her clients, and that her pre-screening qualifications had given her clients faster access to Medicaid coverage. Ms. A stated, "We represent clients at Medicaid. Clients do not have to go through the face to face process. Also there are many fewer deferrals [delays because of requests for additional documentation] this way."

Ms. A. said that approximately 17 hours of her work week were spent assisting clients to obtain Medicaid coverage. The largest single category of her time spent convincing eligible clients to apply for Medicaid (6 hrs/week) followed by telephone contact with CASA/Medicaid (4.5 hrs/week).

Ms. A described the strategies she found helpful in encouraging eligible clients to apply as, "normalization, partialization, and clarification." We can only infer that through these terms Ms. A. was referring to helping clients understand that application for Medicaid is a normal process which many older people go through, and that Medicaid will be able to assist them with specific types of medical care and coverage. In addition, she helped clarify with her clients what Medicaid coverage could provide for them.

When preparing the Medicaid application, Ms. A. said that, "Clarification of Medicaid rules and procedures," was found to be very helpful. When submitting documentation to CASA/Medicaid, Ms. A. sent all via messenger service.

In collaborating with CASA, she said that she called the "CASA director or office manager--going up the chain of command," to get the kind of help she needed for her clients. After the application had been submitted to Medicaid, Ms. A. said that "building a relationship with the local Medicaid office," was very helpful to her in tracking the application. In tracking the application after submission to CASA, "going up the chain of command," was helpful. Ms. A.'s words of practice wisdom were to "do a differential

entitlement assessment to determine the best route into Medicaid [for her clients]."

Mr. B was the second highest-volume respondent of the survey. On a yearly basis Mr. B. stated that he processed approximately 1300 Medicaid applications. Mr. B is a 29-year-old Caucasian male attorney, who had been working with elderly clients for seven years at the time of the study. Mr. B. worked in legal services as the Executive Director/Attorney in Charge. He described his work as direct practice with elderly clients. In addition to the 1300 applicants he directly assisted, he explained that an additional 1500 applications were under his supervision. Approximately 70% of the applicants he assisted each year were female.

Overall, Mr. B said that he did not encounter any difficulties in accessing Medicaid coverage for any of his clients. However, he did indicate that he experienced difficulties tracking the progress of the application after submission to Medicaid in 90% of his applications. In addition, Mr. B stated that 40% of the time he was asked to resubmit documentation already submitted. Difficulty obtaining documentation from clients was experienced 35% of the time, and lack of accurate financial information from clients prior to application was experienced 5% of the time. Mr. B. indicated that he experienced difficulties accessing Medicaid coverage for his clients, "there are delays in processing Medicaid and home care applications, at all stages. They fail to issue written notices [from Medicaid regarding determinations], and fail to send plastic Medicaid cards once the eligibility determination has been made."

Mr. B described the assistance his clients received from CASA/Medicaid as "not helpful." Mr. B. explained, "I think most workers care very little, if at all about clients. They are paper pushers, passing along files from one desk to another. Very few make any concerted effort to assist clients in the application process as mandated under law. Central Medicaid workers (330 west 34th Street) are worse than CASA workers, which isn't saying much."

Possibly because of his training as an attorney, Mr. B. differed in several ways from the other high volume advocates. Of all advocates, Mr. B went to the most Medicaid Fair Hearings. In the year prior to the study, Mr. B. went to Medicaid Fair Hearings 100 times to protest eligibility determinations, and 150 times in response to service authorizations. Mr. B also went to three Medicaid conferences in that year. In contrast with most high volume advocates, Mr. B. had not been trained as a Medicaid pre-screener. Approximately 20 hours of Mr. B.'s work week was devoted to helping clients obtain Medicaid coverage (10 in direct service, 10 in supervision). The largest single category of his time (five hours/week) was spent in litigation and negotiation regarding personnel policy and legal matters related to the Human Resource Administration. Mr. B. said that most of his time was spent in contact with the Human Resource Administration's policy personnel in Medicaid and home care departments, with the New York State Department of Social Services policy personnel, and in contact with the Human Resources Administration Office of Legal Affairs (several times a day), and in judicial litigation in regard to accessing Medicaid for his clients. Mr. B. indicated that he delegated some of his Medicaid related work to his secretary, particularly the photocopying of Medicaid

related documents.

The strategies recommended by Mr. B. were some what similar to those recommended by Ms. A. In encouraging eligible clients to apply for Medicaid, Mr. B. said that providing a "thorough, informed explanation of available services through Medicaid," was helpful. When preparing the Medicaid application, he suggested being "as complete as possible with initial submission, answering all questions and giving in every possible document, keeping copies of all documents sent, and sending everything certified mail, return receipt requested."

When submitting documentation to CASA/Medicaid, Mr. B. had a number of different strategies he found helpful: "Hand delivery with obtaining the signature of the receiver, mail documentation certified return receipt mail, keep copies of documents given in, keep them clipped together, and [he emphasized the importance of] calling to see who has been assigned to the case and when the next step will be taken [in relationship to the progress of the application]."

In collaborating with CASA, Mr. B. said, "always take the first and last name of the person you speak to (at the beginning of the conversation) and don't be afraid to speak to the director of the office, or higher when you feel your client has been wronged."

When tracking the application once it was submitted to Medicaid, Mr. B. wrote, "insist

upon knowing the name of the eligibility worker processing the case at CASA, not just the name of the CASA case manager. This way you can speak directly with the processor as opposed to the middle person (the case manager)."

Ms. C. described herself as a 45-year-old Hispanic woman who worked in a hospital setting. She indicated that she had worked with the aged for the past nine years in her job as a supervisor for the hospital. On an annual basis Ms. C was involved with processing 1200 Medicaid applications per year, 50% of whom were female applicants. Ms. C. stated that she did not encounter difficulties in her ability to access Medicaid for any of her clients, although she mentioned that her clients experienced difficulty completing the Medicaid application and obtaining the related documentation.

Ms. C. also described the assistance her clients received from CASA/Medicaid as "not helpful." Ms. C. wrote, "CASA agencies take longer to make a simple eligibility determination. Patients often leave the hospital without services."

Ms. C did not go to Medicaid Fair Hearings or Conferences. She explained, "We do not have the staff to do this [go to Fair Hearings], patients usually do this themselves." Although Ms. C did not personally go to Fair Hearings, she stated that she recommended them for her clients. She suggested that clients "Utilize the right of appeal [Medicaid Fair Hearings] opportunity to all applicants who are denied Medicaid."

On average, Ms. C. stated that it took her one to two months to get her clients Medicaid coverage. When obtaining Medicaid home care, it took her between three and four months on average. Ms. C. was also trained as a Medicaid pre-screener, and regularly scheduled appointments for her clients' applications. She said that she found the pre-screening appointment helpful in facilitating access to Medicaid for her clients, and that she thought that being a pre-screener had given her clients faster access to Medicaid. According to Ms. C, "We apply for Medicaid coverage to pay the hospital bill. Fifty percent of the time Medicaid determines patients are eligible for community coverage and send them cards."

Ms. C. was one of four high volume respondents who spent their full work week (35 hrs/week) assisting clients in obtaining Medicaid coverage. The breakdown of her hours was as follows (listed in descending order): 15 hours in written correspondence with CASA/Medicaid, 10 hours spent photocopying documents, five hours assisting clients and family members gather documents, and five hours speaking with clients about the progress of their applications. When asked how else she spent her time assisting applicants, Ms. C. wrote, "We set up appointments with clients, do complete interviews, photocopy all documents, write up complete applications, obtain appropriate medical forms and discharge summary, submit application to the Medical Assistance Program (Medicaid)."

When asked about the access strategies she found helpful in assisting applicants, Ms. C. said that "We have the ability to clock in a case with City-on-Line, and Med-E-America." When submitting documentation to CASA/Medicaid, Ms. C. indicated that she did not

think that any particular strategies worked, "once a case is submitted to CASA and the documents are misplaced, they insist you resubmit them."

When collaborating with CASA, Ms. C. said that she found it helpful to speak with a high level manager within the Medicaid's home care division (Ms. T.). Ms. C. indicated that when she wanted to track the Medicaid application after submission, "referring to the Pending Applications Roster report from Medicaid-BMA 173," was her access strategy. When she wanted to track the application once it was submitted to CASA she indicated that weekly phone calls to CASA were helpful. Other access strategies recommended by this advocate were "up to date financial information, and current medical information."

Conclusion

In summary, the high volume advocates were more experienced, on average, than the overall advocate group in processing Medicaid applications. Of greatest practice relevance was their ability to access Medicaid and Medicaid home care approval for their clients within shorter time frames, and with less difficulty than the lower volume advocate group. For most high volume advocates, processing Medicaid applications and related tasks comprised the majority of their work time. Because of their practice experience, ability to secure Medicaid in shorter time frames, and with less difficulty, the strategies recommended by these high volume advocates will be especially valuable to less experienced advocates. In the next chapter, the recommendations of these advocates and

those of the other advocates will be presented.

Chapter 6

Strategies Recommended by Advocates

In the previous chapters, the specific obstacles encountered by client advocates during the Medicaid process were presented. In this chapter, the strategies and techniques recommended by these respondents will be presented. Strategies fall into two general categories: those originated by the Medicaid administration; and those developed by advocates through their practice to confront the difficulties of accessing coverage. The strategies available through Medicaid will be presented first, followed by those developed by practitioners.

Access Strategies Provided by Medicaid

There are three types of access strategies provided by Medicaid; pre-screening, Medicaid Fair Hearings and Medicaid Conferences. The strategies will be presented in this sequence.

Medicaid Pre-screening

Taking advantage of pre-screening training is an access strategy employed by some advocates.

Over one-third (36.3%) of the sampled advocate respondents had completed training as Medicaid pre-screeners. Pre-screening training is provided by the Medicaid administration to train community-based advocates in the preparation of a Medicaid application. Pre-screening takes one full day of training. Through this training client advocates learn how to determine client eligibility, correctly complete the application, and what specific documents are needed to demonstrate Medicaid eligibility. Once an advocate has been trained as a pre-screener she/he is able to schedule appointments for Medicaid applications. Without pre-screening qualifications, a client advocate could wait at Medicaid for several hours before being seen by a Medicaid representative. For advocates who work with large numbers of Medicaid applicants, pre-screening training is considered essential.

Eighty-six percent (86.2%) of those advocates who had been trained as Medicaid pre-screeners, indicated that they found pre-screening helpful or very helpful. Of these, almost one-half (48.3%) said that they thought that having the pre-screening appointment was "helpful." Thirty seven percent (37.9%) indicated that they considered the pre-screening appointment "very helpful" in facilitating access to Medicaid for their clients. Thirteen percent (13.8%) said that they thought that the appointment was "not helpful," but no specific reasons were stated by these advocates. Almost three-quarters (73.5%) of those who were pre-screeners said that they thought that this training had given their clients faster access to Medicaid.

Medicaid Fair Hearings-Strategy for Access

One of the access strategies used by advocates was the Medicaid Fair Hearing. Three-quarters (75.6%) of the sampled respondents indicated that they go to Medicaid Fair Hearings an average of 12 times a year (mean=12.2, r=1-253). Medicaid Fair Hearings are a form of legal due process. As defined by Gifis (1991) due process requires that notice and the right to a fair hearing be provided prior to depriving an individual of an entitlement such as Medicaid (237 U.S. 309). Medicaid Fair Hearings are requested to protest eligibility and home care service determinations. Typically, it is the client's social worker or other advocate who will call or write to request a fair hearing when a client has received a written notice of denial for benefits.

Participating in a Fair Hearing is time intensive for client advocates. The Fair Hearing requires several hours of preparation, in addition to approximately 2-4 hours for the hearing. Since Medicaid Fair Hearings do not usually start on time, the advocate must often wait 1-2 hours for the administrative judge and the representative from Medicaid to appear. Once the Hearing has concluded, a determination is made by the judge. The client and advocate receive a written determination, usually in 4-6 weeks. If the Medicaid representative does not appear at the Hearing, the determination is reversed and the client wins the Fair Hearing.

The high percentage of advocates requesting Medicaid Fair Hearings (75.6%) suggests that elder care advocates may be spending considerable time each month protesting Medicaid

eligibility determinations, in order to ensure access to health care coverage for their clients. Such a finding could imply that access to Medicaid may be viewed as an adversarial system, requiring time-intensive advocacy in order to provide access and protect the rights of clients to this entitlement.

Fair Hearings for Service Authorizations

The same type of Medicaid Fair Hearing is also used by advocates and clients to protest determinations for home care service allocations. A slightly higher proportion of respondents (77.8%) indicated that they used Medicaid Fair hearings to protest the amount of home care service authorized for their clients. On average, respondents requested fair hearings for service authorizations about once every two months (mean=5.74, r=1-35). In contrast with eligibility Fair Hearings, service authorization Fair Hearings were made by more advocates, but less frequently than eligibility Fair Hearings.

Use of Medicaid Conferences

Another strategy for accessing coverage used by advocates is the Medicaid Conference. The Medicaid Conference differs from a Fair Hearing in several ways. The Conference is not a legal procedure like the Fair Hearing. Requesting a Conference does not provide the legal protection of a Fair Hearing, however, it is more time-efficient than a Fair Hearing. Conferences can be scheduled within a short time span. There is usually a 1-2 week wait,

compared with an average two month wait for a Fair Hearing. In addition, the Conference seeks to find resolution to the problem during the conference itself, compared to the delayed determination from the Fair Hearing.

The Medicaid Conference is frequently used to resolve simple problems related to issues of eligibility, service authorizations, amount of surplus income payments, etc. The Conference provides the opportunity for the client advocate and the Medicaid representative to meet and discuss specific problems related to a client's Medicaid coverage and/or services. Of the sampled advocates, approximately one-third (31 individuals) said that they used the Medicaid Conference. These advocates requested Medicaid Conferences an average of 5.22 times a year (r=1-80). Despite the shorter time frame, the above findings indicate that Medicaid Conferences are not requested as often as Medicaid Fair Hearings. Conferences may be utilized less often than Fair Hearings because they are not promoted in the same way as Fair Hearings are. Only more knowledgeable advocates are informed about the conferences through Medicaid related training and advisory councils, while all eligibility determinations and service authorizations include reference to a Fair Hearing.

Practice-Based Access Strategies

Advocates were asked to identify specific strategies they found helpful in assisting their clients during the application process. In particular, advocates were asked to identify the strategies they found effective in: (1) encouraging eligible clients to apply for Medicaid; (2) preparing

the Medicaid application; (3) submitting documentation to Medicaid; (4) collaborating with CASA; and (5) tracking the application after submission to Medicaid and CASA. In addition, advocates were asked to describe any (6) other strategies they found helpful in facilitating access to Medicaid for their clients. A summation of their strategies as well as excerpts from their statements will follow.

(1) Encouraging eligible clients to apply

Strategy: Stressing the Helpfulness of Medicaid

In encouraging eligible clients to apply for Medicaid, the most frequently recommended strategy was to stress the helpfulness of Medicaid coverage. In particular, advocates explained that by stressing how Medicaid-funded services could help clients to remain at home (rather than going into a nursing home), they were able to encourage reluctant clients to apply for Medicaid.

Advocates also recommended emphasizing the financial advantages of Medicaid coverage and carefully explaining its benefits to older clients in order to encourage them to apply. For example, one high volume advocate suggested, "explaining to them that they will be able to obtain services they could not otherwise afford," would be helpful in encouraging eligible clients to apply for Medicaid. A different high volume advocate suggested "comparing the patient's actual medical expenses to the [Medicaid] surplus and trying to show the patient

they would be financially better off with Medicaid."

Another advocate described his strategies as, "outline with them the potential financial benefit, along with the aid in paying medical expenses and stretching their already taxed budget. In the case of Medicaid home care applicants, I share what could be of benefit to their health and quality of life. Secondly, I recruit family members where possible, to encourage (pressure) the client to apply." A different high volume advocate suggested saying to clients, "if you qualify [for Medicaid], you deserve to take advantage of the resources out there."

Strategy: Using Reason with Clients

Advocates recommended using persuasion and reframing with older clients as a strategy to encourage eligible clients to apply. In particular, several suggested that by presenting Medicaid as an entitlement, like Social Security, it would help encourage some reluctant eligible persons to apply. Advocates suggested that reframing Medicaid as an entitlement in this manner also would help to reduce part of the stigma associated with it as a "welfare" program.

Suggested one advocate, "it is important for the client to see Medicaid as something that they have earned, rather than welfare, as our clients tend to be proud and independent coming from strong work ethic heritages." One high volume advocate suggested describing Medicaid "as an entitlement--something they are eligible for and may need," as helpful to him in

encouraging eligible clients to apply for this benefit. In addition, he suggested stating "that [Medicaid] surplus is a small amount compared to the total value of medical/home care services," the person can receive through Medicaid. In addition, several advocates suggested explaining to clients that they would not lose their Medicare coverage--and that they may be able to continue to see their primary physician after they were covered by Medicaid. According to advocate statements, fears of losing Medicare coverage and/or their primary care physician are occasionally mentioned by eligible clients as reasons they are reluctant to apply for Medicaid.

Strategy: Counseling

Advocates stated that they considered counseling with older clients as very effective in reducing client resistance to applying for Medicaid. Specifically, advocates indicated that counseling was helpful in reducing client fears and guilt about applying for Medicaid, as well as dispelling some of the myths clients associated with Medicaid. Counseling was also recommended by advocates as a way to help reduce the stigma many reluctant applicants associated with Medicaid.

(2) Preparing the Medicaid Application

Strategy: Involving the client and family

Advocates overwhelmingly recommended making a clear check off list of all the needed Medicaid documents for clients (and/or their families). One advocate said that she gives "the patient and the family a list of what's needed instead of just explaining it verbally." Stated one high volume advocate, "the fact that we mark a printed documentation form as to what is needed as well as give detail to any type of letter needed to be written by landlord, a friend, a doctor, etc., seems to give them [clients] confidence."

In addition, advocates suggested providing support to the client and family members in locating necessary documentation. In fact, respondents explained they were most effective when they involved and closely guided the client and their families throughout the entire application process. One high volume advocate suggested, "listing with a black marker, in large letters, all documents needed," so that the client and/or family would clearly understand what documents were needed for the application. Stated another high volume advocate, "be clear with the client and make sure they do not leave without understanding everything that they need for the application." Another experienced advocate recommended, "preparing family members early so they pull together documents for the application." Another advocate recommended "never make an appointment with Medicaid until all documents are collected, and remind the client that benefits cannot begin until they collect the documents."

Strategy: Excellent record keeping .

"Document and Photocopy EVERYTHING"

Advocates recommended keeping excellent records of everything submitted to Medicaid, which included making copies of all documents submitted, and keeping track of what was submitted-- when and how.

Suggested one advocate, "I make copies of all requested documents (pension stubs, birth certificate, gas/light bills, rent receipts, etc.) and hand deliver them to the Medicaid worker or receptionist and get a receipt. In obtaining other documents, I explain to the client how important these documents are, and get his or her trust and copy them, if the client is unable to."

One advocate described what he does to prepare the Medicaid application as, "making Xerox copies for the client's record and second copies for them to give the workers at Medicaid . . . it saves the Medicaid worker's time and effort and often favorably disposes the worker's attitude to the client's benefit. I tell the client to be through in gathering the information and we prepare the entire application prior to setting up an interview. Clients are instructed that they should not be discouraged from applying. They have the right to apply and must apply if they wish."

One high volume advocate recommended "always documenting carefully and providing all documentation the first time to reduce deferrals (delays for additional documentation). Send covering memos and letters regarding anything problematic. Make sure to think out in advance questions Medicaid may ask and provide documentation up front as deferrals waste weeks."

Strategy: Anticipate specific problems--plan a good defense

A number of advocates anticipated the types of problems or questions which would be raised in relationship to particular applications. Wrote one advocate, "anticipate the issues which may arise and meet them head on. For example, if you anticipate a `transfer of assets' issue, provide evidence that the transfer was made for some purpose other than to qualify for Medicaid." A different advocate suggested, "documenting everything prior to submitting an application. Make certain there's an explanation for everything, anticipate Medicaid's questions."

Strategy: Develop relationships with documentation administrators

In order to have an easier time securing documentation, some advocates suggested cultivating interpersonal relationships with bankers, administrators of Social Security and the Department of Vital Statistics. Advocates indicated that utilizing these relationships could help to ease the delays and obstacles often encountered when trying to obtain needed documentation.

(3) Submitting documentation

"Hand delivery, photocopy everything, document dates of submission."

In submitting the application and documentation to Medicaid, advocates recommended two central strategies they found effective: providing full explanations, and obtaining proof of submission.

Strategy: Provide full explanations

When submitting the application and documentation to Medicaid, advocates recommended providing explanations for all financial transactions above $500 in order to avoid eligibility deferrals and other delays in obtaining an eligibility determination.

One high volume attorney advocate said that she used "detailed cross-referenced, color coded charts showing money movement, with a letter that spells out every detail of the documentation method," to provide a full explanation of the clients financial history when submitting the Medicaid application.

In the event that specific documents could not be obtained, advocates recommended including letters of explanation along with the other necessary documents. For example, if a late husband's death certificate could not be located from a foreign country, advocates suggested including a letter of explanation which included a description of efforts made to obtain such.

Another highly experienced advocate suggested, "giving clients the Medicaid documentation guide early to assist them [in obtaining documentation]." This advocate also recommended "using a checklist to make sure all documents are complete, and a transaction sheet to help a client document all withdrawals and deposits to submit with bank records." The same advocate also recommended "writing a cover letter or memo to go over difficult issues and explain in advance any potential documentation issues." The access strategy of one highly experienced advocate was to "complete the entire application process prior to referring [the client] to CASA/Medicaid, and to avoid an M11Q (medical request for home care) from expiring during the Medicaid process."

Strategy: Obtain Proof

Obtaining some kind of proof of submission was suggested by most advocate respondents. Advocates suggested always getting a signed, dated receipt for all documentation submitted, and if possible, having all documents hand delivered. Some recommended the use of Federal Express and messenger services, overnight delivery and the faxing of any additional information. Other less expensive methods of sending applications and documents including

certified mail, with a return receipt requested, and express delivery, along with a follow-up telephone call were also recommended.

"If anything is sent, it is sent return receipt requested or hand delivered and a receipt is demanded," wrote one advocate. "If the application is incomplete or follow-up is needed, a call is made a few days later to determine who was assigned the case," added this advocate. Several high volume advocates said that whenever possible they would have a responsible family member hand deliver the Medicaid application and related documentation. If a family member was not available to submit the application, one high volume advocate stated, "always hand deliver and keep notes on the dates, times and to whom papers were submitted." Another advocate recommended faxing documents, but only after calling, and to document case records before and after the fax.

(4) Collaborating with CASA/Medicaid

Advocates were asked what strategies they found helpful in collaborating with CASA/Medicaid on behalf of their clients. Advocates suggested developing interpersonal relationships with CASA/Medicaid workers, maintaining professional composure, utilizing the organizational chain of command, and keeping accurate records were recommended as very effective intervention strategies. To follow will be a description of these strategies.

Strategy: Cultivate interpersonal relationships

"Validate their enormous case loads, assist them whenever possible."

The majority of respondents recommended developing interpersonal relationships with CASA/Medicaid workers. As suggested by one high volume advocate, "develop personal relationships with CASA/Medicaid to enable the work to go more smoothly. Establish rapport with the supervisors and case workers, get their permission to call again soon, and then do so."

Another advocate explained the strategies he used in attempting to cultivate a good working relationship with Medicaid personnel, "usually I ask the worker, 'what can I do to help you do your job?' This kind of puts a twist on the usual inquiry of 'what are you doing to help my client . . . why is it taking so long?' This positive offer makes the worker an ally in the [application] process."

Other advocates recommended meeting with them face to face whenever possible, including meeting them at the client's home during their initial assessment. One advocate explained, "I will sometimes meet the CASA worker at the client's home to interview. The client is usually familiar with me and more at ease. I can also provide information, regarding the client's need for service that the client may forget. I encourage the worker to contact me if there are problems with the application. I also apply for Section 8 or other benefits for other clients on

the worker's case load which fosters a cooperative relationship."

One advocate said that she has "developed a good working rapport with our CASA office, particularly because we work in the same building. I have learned to 'smooze' with the staff, and it works well for me and ultimately for my clients."

Some advocates recommended developing one or two key contacts at CASA/Medicaid who could be called upon when needed. Several high volume advocates suggested developing contacts with supervisors or even CASA/ Medicaid directors to help facilitate the application process. Another strategy recommended by several advocates was to offer as much assistance as possible to the CASA/Medicaid worker, in an effort to gain their cooperation and help in return.

Strategy: Professional use of Self-Maintain composure

"Be cordial, yet persistent," in advocacy efforts.

Interestingly, many advocates stressed the importance of maintaining emotional composure when interacting with CASA/Medicaid personnel. Specific suggestions were to "stay calm," "do not lose your temper," "be cordial, yet persistent." Because of the multiple obstacles encountered by advocates in their attempts to obtain Medicaid for their clients, there may be instances which can be very emotionally taxing. Advocates recommended the use of

professional composure, even in the most trying of circumstances. In the words of one high volume advocate, "no matter how miserable the Medicaid worker is, be sure you remain as sweet as pie." Another high volume advocate recommended being "reasonable in advocacy efforts," and "cooperative instead of demanding," as helpful strategies for interacting with CASA/Medicaid personnel.

Strategy: Utilize the chain of command

"Going to the top."

When interpersonal relationships and emotional composure were not effective in overcoming specific obstacles, advocates strongly recommended calling the worker's supervisor and/or "going to the top as soon as possible." Utilizing the chain of command was recommended by some advocates as a way to use the organizational structure to exert influence upon difficult situations and problem workers.

In contrast, one high volume advocate strongly recommended doing so only out of necessity. "Contact supervisors or directors only when absolutely necessary. All avenues of collaboration with the case worker should be exhausted before moving to the next level of administration. If necessary, make it clear to the case worker that we will be calling their supervisory or director."

Strategy: Record keeping

Another strategy recommended by several advocates was to keep a log of all phone calls with CASA/Medicaid workers. Advocates recommended always obtaining "the name of the person you speak to." Advocates also recommended confirming conversations with workers in writing to avoid any possible misunderstanding and to provide documentation of what was agreed upon between the advocate and the worker. In addition, advocates recommended establishing time frame commitments from CASA/Medicaid workers and putting these in writing also.

(5) Tracking the application after submission to Medicaid

Advocates were asked to describe the strategies they found helpful in tracking the Medicaid application after it was submitted. Advocates recommended several strategies which will be presented: consistent phone contact; developing collegial relationships; utilizing the chain of command; and obtaining direct access of information.

Strategy: Consistent phone contact

Advocates overwhelmingly recommended keeping in consistent phone contact with CASA/Medicaid, "work with them to track the progress of the application." One advocate said, "contact the supervisor to keep track of the case, contact the worker and generally keep

after people. I document all calls and letters." Another advocate recommended being very persistent in establishing phone contact by "calling repeatedly. Don't wait for the worker to return your call. She or he won't." Stated another advocate, "calling the eligibility unit or the worker assigned can prod along the process. The workers will usually work more timely if watched from afar, or prodded by contacts from other agencies."

Strategy: Develop collegial relationships

Advocates again indicated the importance of the development and cultivation of collegial relationships with CASA/Medicaid staff. Advocates suggested utilizing these collegial relationships as an effective means of obtaining information regarding the status of their clients' applications.

Client advocates at an uptown agency described what they considered as a very good collegial relationship with a local hospital and how this relationship helps them to access Medicaid for their clients. "We have a system with X Hospital's Medicaid office and they give use all the feedback we need. They are extremely helpful and work very closely with us."

Strategy: Utilize the chain of command

When they were not effective in obtaining needed information or help from line workers at CASA/Medicaid, advocates recommended the use of the supervisory hierarchy to exert

influence upon these workers. The majority of advocates strongly recommended contacting supervisors and district/department directors when they were not able to obtain results from line workers. Wrote one advocate, "work with the case worker when possible, and speak to the supervisor or director when necessary."

Other respondents suggested going directly to supervisors or directors rather than going up through the organizational chain of command. One advocate recommended going outside the Human Resource Administration (HRA) organizational structure and writing directly to local politicians and Congressmen when no resolution or determination was made within a "reasonable time frame."

Strategy: Record Keeping

"Keep a log, a list of dates everything was submitted, whom you spoke to. Confirm everything in writing."

In tracking the progress of the application (as in collaborating with CASA/Medicaid) advocate respondents stressed the effectiveness of meticulous record keeping in order to track the progress of applications after submission. One high volume advocate recommended "calling the office where the application was submitted. If an unusual delay occurs, call the info line and have a tracer put on the case."

Strategy: Emotional composure

The importance of maintaining emotional composure, being patient yet persistent in tracking efforts were again recommended by advocate respondents as helpful strategies. Even though advocates may not be able to change the Medicaid system, they can make good use of their professional skills when interacting with individual CASA/Medicaid personnel. Maintaining composure throughout difficult situations was found to be very helpful for many respondents. One highly experienced advocate recommended "treating them [Medicaid workers] as professionals, avoiding an adversarial posture, and retaining a sense of humor," as helpful strategies to maintain emotional composure when interacting with CASA/Medicaid personnel.

Strategy: Direct Access of Information

Several advocates recommended calling the Medicaid eligibility unit directly to track the application rather than attempting to obtain this information from line workers or supervisors. In addition, advocates recommended using the HRA information line to seek the status of the application. According to one highly experienced advocate, "using the HRA Info Line (1-718-291-1900) can provide either an answer or a next step to take," in tracking the application.

Another advocate recommended calling the local CASA/Medicaid office early or late in the day to obtain application status information. One advocate recommended requesting a Fair Hearing if a determination had not been made within 30 days.

(6) Other general strategies recommended

Advocates were asked to also include other, effective strategies they found helpful in facilitating access to Medicaid for their clients. Respondent suggestions fell into the following categories: being a knowledgeable advocate; participating in Medicaid Advisory Councils; using Medicaid satellite offices; and utilizing the legal system.

Being a Knowledgeable Advocate

Advocates recommended being a knowledgeable advocate by keeping up-to-date with Medicaid regulations, policies, and procedures. Advocates stated that having up-to-date information helped them to be most effective in facilitating access for their clients. Advocates stated that at times they needed to inform CASA/Medicaid representatives about the most recent Medicaid regulations and policies. For example, one social worker said that she frequently had to "FAX [Medicaid] regulations to case workers." Having such information gave advocates the edge they needed to help them access coverage for their clients most effectively.

Participation in Medicaid Advisory Councils

Several advocates recommended participating in the borough-wide Medicaid Advisory Councils as a way of keeping abreast of recent Medicaid regulations, policies and procedures.

Valuable contacts for networking within the Human Resources Administration are often mentioned at these meetings. Advocates often shared effective access strategies at such meetings as well. Wrote one advocate, "attending the Medicaid Advisory Council meetings allows me to find out who the upper administrators of community Medicaid are, and how to access them. When necessary, I will contact them on behalf of a client."

Medicaid Satellite Offices

Advocates recommended using Medicaid satellite offices to submit the Medicaid application rather than the main Medicaid offices. Medicaid satellite offices are located throughout the city usually at public hospitals like Bellevue and Metropolitan. An advocate can make arrangements to have the application processed at a local satellite office where there is usually less wait and quicker turnaround time for determinations.

Utilizing the Legal System

Referrals to elder care attorneys or use of the legal system, including Medicaid Fair Hearings were mentioned by advocates as strategies they found successful. In recent years there has been a growth in the market of elder care legal specialists, who market their services to older individuals and their families. Elder care attorneys are well versed in Medicaid Law, including it's regulations, guidelines and policies. An elder care attorney may advise a client or family member how to transfer or protect assets in order to qualify for Medicaid. The use of such

specialists is basically limited to individuals who have the financial resources to employ their services. Offices such as Legal Services for the Elderly, or the Volunteer Office of Legal Services can provide legal counsel at low or no cost to the client or family.

Conclusion

In summary, the strategies recommended by advocates were primarily based upon their own practice experiences. Specific strategies included the use of Medicaid Fair Hearings, Conferences and pre-screening training--all provided by the Medicaid Administration. Advocates also provided practice-based strategies suggestions for accessing Medicaid. Of most practical importance were their recommendations of involving the client and their family in preparing the Medicaid application, the importance of excellent record keeping and documentation, as well as keeping good tracking records. In addition, advocates gave suggestions as to how best collaborate with Medicaid personnel--possibly the most challenging part of their role as advocates.

Chapter 7

Findings: Client Responses

Introduction

Eight female clients of Project SCOPE met the criteria of the study and were interviewed in-depth during the months of July and August 1992. The goal of interviewing these clients was to obtain an understanding of the clients' experience in applying for Medicaid. Findings from these interviews will be presented in this chapter. Client respondents were assigned a category of either "pending" or "approved" depending upon their Medicaid status at the time of the interview. Four women were interviewed within each category. A decision was made to interview these respondents in a cross-sectional rather than a longitudinal manner, as the potential for physical illness and/or mental frailty with the elderly population made a cross-sectional study more practical.

Description of Client Respondents

Demographic Background

The average age of the women interviewed was 81 years of age. Six out of eight women had been born in New York City, one was born in New Jersey, and another was born in France. Three women were widowed, two were married, two had never been married, and one was divorced. Five of the eight women lived alone, two were living with their spouses, and one woman was living with her sister at the time of the interview. In the two married households, the husbands were also physically frail and were in need of Medicaid as well. Almost all the women had close family members living in the greater New York Metropolitan area. Two women listed children as their closest family members; the other women listed nieces and nephews. Almost all children lived in close proximity to New York City. One woman also had a son living in Texas, as well as a son in New Jersey.

Four women described themselves as Catholic, three said they were Jewish, and one said that she did not affiliate with any specific religion. All eight women were Caucasian, and had worked for various lengths of time when they were younger. These women worked at various jobs-- three women as secretaries, one as a bookkeeper, one as a translator and artist, and one at a pencil factory. Another woman had been employed as a fund-raiser with a nonprofit organization for 15 years, and the remaining woman had been a research assistant for three

years. The average length of employment for these women was 20.81 years. Of the eight, three women stopped working in order to care for their children or other family members. The other women continued to work without interruption. One woman said that she had to keep working because she had two small children and was separated from her husband.

Medical Coverage

Although all were covered under Medicare, their coverage did not provide them with the type or amount of medical or home care service they needed. Six out of eight women had additional Medigap coverage through Blue Cross/Blue Shield and AARP, but needed to apply for Medicaid for home care. One woman said that she was applying for Medicaid because she was afraid that she would need to go into a nursing home and would need Medicaid to cover her care. At the time of the interview, the women who were pending Medicaid spent an average of $200 per month for out of pocket medical expenses (i.e., medications), which were not covered by Medicare or their Medigap plans. In contrast, the women who had Medicaid spent an average of only $53 per month for medical expenses not covered by Medicare, Medicaid or their Medigap policies. Two women explained that on occasion they had gone without food and other essentials in order to pay for medical expenses which were not covered by their medical insurance.

Motivation for Applying for Medicaid

A variety of reasons motivated these women to apply for Medicaid. When interviewed, all eight women said that they agreed with the statement "I am applying for Medicaid because I really need its benefits." Three-quarters (six women) applied for Medicaid primarily because of their need for home care services for either themselves or their spouse. Two women said they applied because of outstanding hospital bills they were unable to pay. Two said that they also applied for Medicaid because of their need for medications and medical supplies.

The Decision to Apply for Medicaid

For any entitlement, more people are eligible than receive the benefit. People decide to apply for a specific entitlement for many reasons. I wanted to understand how these women made their decision to apply for Medicaid. I also wanted to find out who, if anyone, helped them decide to apply. As the director of a social service program, I wanted to understand what role, if any, social service professionals played in helping them apply for this entitlement. In addition, I wanted to assess what factors, including need for home care and other medically related care, influenced their decision to apply for Medicaid. All of the women interviewed were asked how they decided to apply for Medicaid, who helped them to make the decision, and why they had not applied previously.

Why had they not applied previously?

Each woman was asked why she had not previously applied, even she though she was eligible. Asking this question would indicate what factors changed to motivate each of them to apply for Medicaid. In general, their responses indicated a range of reasons: abilities for self care, feelings of independence and dignity, limited information regarding their eligibility, and surplus income/resources.

In the Medicaid pending group, two women gave similar reasons for not applying previously. One woman said that she had not applied for Medicaid before "because I was getting along. I could take care of myself." The other woman also explained that she had not applied before "because I was able to take care of myself. I've always been able to take care of myself." For another client, "it was a matter of dignity. I didn't want to feel as though I was on welfare. I never had to in my life."

For the women who already had Medicaid, their abilities for self care and a lack of information regarding eligibility were factors which influenced when they applied. For example, a lack of information about eligibility prevented one woman from knowing that she was eligible. She stated, "I didn't even know about Medicaid, until the hospital social worker suggested that I apply to pay for my hospitalization." Another woman explained that while she had known she was eligible to receive Medicaid, it was not until she was physically unable to care for her husband that she decided to actually apply for coverage.

The Role of Formal and Informal Caregiving

Each woman was asked about the kind and amount of care she was receiving at the time of the interview to evaluate the amount of informal (from friends, neighbors, and/or children), and formal (through Medicare, Medicaid, or private home care) assistance she received. The two groups differed in their reliance upon these supports.

The women who were pending Medicaid relied upon a combination of both formal and informal care-giving assistance. Three out of four women received assistance from their neighbors and relatives. One woman, who did not receive any informal care, relied upon a combination of two different types of formal care (through a nonprofit agency and from a privately hired home care worker).

In contrast, the women who had Medicaid relied almost exclusively upon the formal care they received through Medicaid. Only one woman, who lived with her son, received any informal assistance. By having Medicaid coverage these women were able to get more hours of home care. On average, the women who had Medicaid received more hours of home care per week than those who had Medicaid, an average of 88 hours per week compared with 24.5 hours received by the women who did not have Medicaid.

Other Services Received

In addition to the home care services these women received, five out of eight women also received transportation services through Project SCOPE. Two women also had EPIC (Elderly Prescription Insurance Coverage) which provides assistance with the payment of prescriptions. Surprisingly, the two women who had EPIC also had Medicaid. As these women described EPIC coverage as extremely helpful, we could infer that EPIC provided additional prescription coverage not provided by Medicaid.

Client Descriptions

The Medicaid Pending Group

There were four women who were pending Medicaid at the time of the interview. Each woman will be described, as well as the circumstances surrounding her decision to apply, and her needs for care. Their names have been changed to preserve their confidentiality.

Debra L.

Debra L. was an 89-year-old widowed Jewish woman had worked for 15 years as a fund raiser for a nonprofit organization. She never worked after she married. At the time of her interview, Debra was depleting her life-savings in order to supplement the home care services

she was receiving through a nonprofit organization. She anticipated that she would need even more hours of care than she had, and would need Medicaid to pay for her care. In addition, she feared she might need to go into a nursing home in the future. Debra said that she needed to apply for Medicaid because, "I need Medicaid in order to get help in this home, or in a home. I need help with brushing my teeth, getting dressed, etc." She described her reasons for applying for Medicaid, "I have to apply for Medicaid in order to go into a home. If I stayed here and had help for 12 hours a day I would not have to go to a home. I need help with dressing, bathing and my meals."

Debra described a sense of despair over her physical condition, "You live too long, you shouldn't live too long. I'm so full of fright. What's the good of it? You have nothing to look forward to, no place to live. I have a heart condition, severe arthritis, and my lungs are not good. I led a very full life for an old woman. What broke me was that three years ago I fell right here and smashed my right hip, and I've been going down the hill ever since."

Ruth B.

Another woman in the process of applying for Medicaid was Ruth, a 79-year-old single Catholic woman. Ruth, who lived with her sister, worked as a secretary and administrative assistant for 50 years. She stopped working to care for a younger sister who later died. Interviewed in her hospital room, Ruth said, "a lack of money" motivated her to apply for Medicaid. At the time of the interview Ruth said that she was spending approximately $300

per month on medical expenses that were not covered by Medicare or AARP. She said that her hospital social worker and her case manager from Project SCOPE had convinced her to apply for Medicaid to obtain the in home care she needed.

Ruth explained that she needed Medicaid to provide her with home care assistance. Ruth stated, "I applied in February 1992 and I'm still waiting [it was July at the time of the interview]. It seems that I always have all the reasons to get Medicaid. I should have 'round the clock care. Once I paid a woman $175 for one night! The rest of the time, my sister took care of me. My sister called the doorman to put me on the commode, and then she would call him again to take me off the commode." Ruth explained that she needed to apply for Medicaid, "especially for the home care. I got so weak after the last chemotherapy that I could not stand. I need to have someone with me at all times. My sister was helping me but then her doctor said that she shouldn't lift--that she would get a heart condition herself." At the time of the interview, Ruth had been gathering the documents for Medicaid and spending her life savings in order to pay for care.

Mary M.

Another Medicaid applicant is Mary M. Mary is a 79-year-old, never married Christian woman worked as a secretary and a research assistant continuously for 45 years. Her closest family members are a niece and a nephew who live in Philadelphia and Boston, respectively. At the time of the interview, Mary was spending approximately $50 per month on medically

related expenses that were not covered by Medicare or Blue Cross/ Blue Shield. Mary said that she applied for Medicaid "because I'm going to run out of money. I was sick so often that I needed home care and that's what's been eating up my money. It was difficult for me to apply for assistance because I'm a very independent person. I don't like the idea of applying for assistance. I was able to take care of myself. I've always been able to take care of myself."

Obtaining Medicaid coverage would mean that she would still be able to receive home care services after she depleted her life-savings. At the time of the interview she was spending-down her savings on home care services while awaiting a decision from Medicaid.

Allison C.

A 76-year-old widowed Catholic woman named Allison was interviewed in her apartment in a New York City Housing Authority-sponsored building for senior citizens. During her younger years she had worked for more than 15 years as a secretary and bookkeeper for an accounting firm. Allison continued to work after she had children because she was separated from her husband. Her daughter, who lives in Brooklyn, was described as her closest family member.

Allison explained that the primary reason she was applying for Medicaid was because of her need for home care assistance. " I tried to do all that I could do, but I can't keep it up." In addition, she said that the high cost of medications motivated her to apply for Medicaid.

Allison said she applied for Medicaid because she also needed help paying for her prescription medications. At the time of the interview, Allison stated that she was spending approximately $250 a month on her prescriptions. In addition, she explained that she was not seeing her physician regularly because she could not afford to.

Allison explained that her medical needs had been increasing over the past few years. Although she had received Medicaid before, her coverage had been discontinued after Medicaid discovered she had another bank account with her daughter. Now that her assets were within Medicaid's guidelines, Allison was applying again for coverage.

Medicaid "Approved" Group

Four women who had obtained Medicaid coverage within the prior year were interviewed. Each woman will be described, as well as her reasons for applying for Medicaid. Their names have been changed to protect their confidentiality.

Pamela M.

Pamela M. is a 67-year-old divorced woman who was born in France. For 30 years she worked at various jobs, including managing a clothing boutique and translating letters of credit from English to French. When her daughter was a young child, Pamela took care of other small children, and taught French to various individuals. Her daughter lives in New

York and keeps in close contact with her.

Pamela's decision to apply for Medicaid was motivated by large hospital bills that Medicare did not fully cover. Pamela stated that, "big debts motivated me to apply for Medicaid. What really influenced me to get Medicaid was those big bills from the hospital. I had big bills ($4,000) and Medicare only paid for part. I've had two heart attacks. I was going crazy with these enormous bills. My case manager suggested that I apply for Medicaid. It took a year before I got Medicaid, but they paid for all of my bills. I found out that I could use the card [Medicaid Identification] to pay for medications, but there are only certain drug stores that will accept it. I had large bills. The hospital paid for the first heart attack, but then there were outstanding bills more than $1,000 and some doctor bills too. I used to get the bills every month. At first I didn't even know about Medicaid. I didn't know what was available. It's not like in France where everything is done for you. Here, no one will tell you what to do. I didn't know about it, it was Nancy [case manager] who mentioned it. Thank God for social workers." At the time of the interview, Pamela had been on Medicaid for approximately nine months.

Mona K.

Another woman, Mona, is a 79-year-old married Jewish woman who lives with her husband. She told me that she had worked for about seven years as a bookkeeper, but had worked only part time when her sons were young, and didn't go back to work until they were older. Now

her sons live in New Jersey and Texas, and maintain close contact with her by phone. At the time of the interview she and her husband had been on Medicaid for 10 months.

Mona explained that she applied for Medicaid coverage primarily so that she would be able to get assistance with caring for her husband who suffers from rheumatoid arthritis. She said that she also had arthritis and was in constant pain which prevented her from helping her husband and caring for their home. In describing her reasons for applying for Medicaid, Mona said, "I couldn't do it any more. I have a heart condition, muscular arthritis, body aches. I'm in constant pain. I'm always taking something. He has severe rheumatoid arthritis. He needs assistance to walk. His hands and toes are all twisted too. He looks nice, but you should have seen him months ago, he lost 25 pounds. He had one foot in the grave. You do what you have to do. I try not to think about it. I can't do what I used to do."

Mona further explained that she applied for Medicaid so that she could provide care for herself and her husband without depending upon her children. " I need the home care. It is financial. I don't have the money to employ anyone privately. All your life you give to your children. They help all they can, but I can't keep on imposing on them for help. They have their own families . . . sometimes you have to go your own route." Having Medicaid coverage has allowed Mona to care for herself and her husband without financially depending on her children.

Kitty A.

The oldest woman interviewed was a 95-year-old widowed Jewish woman named Kitty. She was born in New York City where she has lived ever since. Before she married, she worked for about 10 years doing stenography and accounting for her family's sporting goods business. While working in her family's business she met her husband. After her marriage she never worked again. Kitty said that she raised two daughters, but one had died several years ago. Her remaining daughter lived in New Jersey and was in close contact with her.

According to Kitty, she applied for Medicaid while she was in the hospital in critical care. She said, ""I needed to apply for everything. There was medicine, pampers. I was in critical care. I was given intravenous feedings. I didn't know anything about it [the application process]. My daughter took care of it all for me." Because of her hospitalization, and poor health at the time of her application, a subsequent follow-up telephone interview was conducted with her daughter in order to obtain more information about the application process.

Agnus G.

The last woman interviewed was Agnus G., a 71-year-old married diabetic Catholic woman who lived with her husband and adult son. Agnus worked for five and one-half years in a pencil factory cutting the insides of pencil boxes before she got married. After her marriage

she never worked again. She said that her son was a sick child and she needed to take care of him.

Like Pamela, Agnus applied for Medicaid because she had large outstanding medical bills. According to Agnus, "it was getting hard to manage [financially]. I owed one doctor $11,000. We applied for Medicaid to pay for our medications and hospital bill. I was getting sicker and sicker, that's all. I was in and out of the hospital for two years. I'm still getting bills." Agnus, said that she was spending $150 per month on medical expenses that were not covered by Medicare, Medicaid, or Blue Cross /Blue Shield. At the time of the interview, Agnus had been on Medicaid for six months.

Experiences Applying for Medicaid

Each woman was asked to describe her experience in applying for Medicaid. Their case managers appeared to be play an instrumental role in assisting most of these women in their application for Medicaid. For example, Pamela said her case manager, "Nancy was the one who was able to get the form and fill it out, etc. Because I didn't know about Medicaid, I felt very dumb. So I inquired of my friends, and they said that they didn't know any thing about it." Mona also said that her case manager, "Diane was the one who helped me with it."

Hospitalization preceded Kitty and Agnus' applications for Medicaid. Kitty said, "My daughter applied for me when I was in the hospital." Agnus explained that she was referred

for assistance with the application by the hospital social worker. "I think when I was in the hospital, for diabetes in November, one of the social workers there referred me to you people [for assistance with the application]."

Emotional Content Related to Applying

All women expressed a range of emotions related to their application for Medicaid. Several stated that they did not really want to apply for Medicaid but felt that they had to in order to get the kind of medical care they needed. For example, as Debra said, "I feel that I must, but I still resent it. I've never owed anyone a penny, and the thought of spending the rest of my life depending on charity really irks me to no end."

Ruth also expressed similar feelings about applying for Medicaid, "Now I would like to have it because I need it. I feel as through I'd rather not have it, but it's out of necessity." Mary expressed her feelings about applying, "I'm a very independent person. I don't like the idea. I thought I was set [financially]. I made my money in the 70's. If we were still in the 1970's, we'd have a lot of money, that's the problem with this age."

Applying for Medicaid was not a pleasant experience for Mona. She described the experience as "degrading. I didn't like it. I didn't like the responsibility of it." She added that she had thought about stopping her Medicaid coverage because of the negative associations she had with it, "I'd like to stop, but I can't. I can't help him [her husband] out of bed, or pay for my

medications, so I'm caught."

Significance of Applying for Medicaid

The decision to apply for Medicaid and the process of applying illustrated ambivalent feelings on the part of most of the women interviewed. For example, seven out of eight women said that they agreed with the statement: "Medicaid is good for those who really need it." But when asked if they agreed with this statement: "I've worked hard all my life, paid taxes. I feel entitled to all I can get from the government," only four said that they agreed. These findings suggest that half of the women who applied for Medicaid may not feel they were entitled to receive its benefits, but applied for Medicaid despite their feelings.

For example, Debra said, " applying for Medicaid means that I get on the poverty level and I'm on public aid. It's bad enough that I accept your good neighbor aid. Some people feel that they are entitled. I don't feel that way. I want to pay my own way. It's demeaning."

When asked what applying for Medicaid meant to them, several women also expressed low spirits, fear of the stigma, and fear of loss of independence. As their statements illustrate, some of these women experienced negative associations with Medicaid, but applied for the benefit despite their feelings.

During her interview, Ruth expressed fear of the stigma in relationship to her application for

Medicaid. Ruth explained that applying for Medicaid means, "crushing your spirit. I put it off for a year because I didn't want to have the association of Medicaid. It's a feeling of accepting things that I'd rather not accept. It turned out to be such a necessity that I had to put those feelings aside." Applying for Medicaid "makes me feel less independent. I've always taken care of myself." As these statements illustrate, the decision to actually apply for Medicaid may represent a temporary resolution of their ambivalent feelings in relationship to this entitlement.

Obstacles to Obtaining Coverage

Client and advocate findings were fairly consistent in regard to the kinds of obstacles encountered while accessing Medicaid coverage. A long application process, difficulties in documenting eligibility, and the lack of assistance with CASA/Medicaid personnel were experienced by most of the clients interviewed. The specific difficulties encountered by clients during the application process were found to be consistent with those described by their advocates (see Chapters 4 and 5). Difficulties obtaining documentation, and lack of assistance from Medicaid personnel will be described from a client-based perspective.

Extremely long application process

The experiences of the clients in applying for Medicaid illustrated the same difficulties evidenced by their advocates. From the time of their initial application, the women who had

Medicaid coverage said that it took approximately eight months on average for them to receive coverage. According to Pamela, "It took about a year, six months. The first time I applied. I was denied because I had savings that I transferred to my granddaughter. They did not have the proper papers. So we went to a fair hearing and we submitted more and more papers. It's very confusing for someone who does not know the proper terminology."

On average, the women pending Medicaid had been awaiting coverage for an average of more than four months at the time of their interviews. Why was it taking so long for these women to get Medicaid even though they had a social worker advocating for them? A variety of obstacles were experienced by these women during their application process.

Documentation

Several women experienced difficulty obtaining the eligibility documentation needed for Medicaid. For example, Pamela said the application process, "was the soup line of constant new papers. It was a great deal of searching for papers, because I realized that so much depended on it. It's not like, here are your needs and here is how your needs will be met. It was a struggle, I was very nervous because those bills kept coming every month and I didn't know what to do. They refused me at first. I had to go to a fair hearing because of my life savings. They didn't have the proper papers that demonstrated that I had transferred my savings to my granddaughter. Then the papers went to Albany, and so on. It was very complicated because they don't tell you anything."

Kitty also experienced difficulties regarding documentation during the application process. According to her daughter, Kitty experienced difficulties finding "records of when she was in the hospital, paid telephone bills, and so forth." Kitty said that Medicaid demanded "an enormous amount of documentation. It took 2-3 days to gather the documents. It was difficult to access all the documents."

Agnus also experienced difficulties in accessing coverage but relied upon her case manager to assist her. "I guess I didn't understand a lot of stuff, and Silvia [case manager] tried to explain it to me. I experienced difficulties on account of all these doctors and all these bills. I was always making myself a nervous wreck. I had to go through 4-5 packages--of different bills. These are the bills I paid, a lot of bills I owed. I didn't know about those bills. I didn't know if I had to pay it or not."

Lack of Assistance from CASA

Overwhelmingly the clients interviewed described a lack of assistance from Medicaid case workers, particularly from the Medicaid office mandated to assist recipients with obtaining home care services (CASA). Mona said she experienced difficulties not in documentation because, "I keep everything," but in receiving assistance from the CASA. Mona said that she experienced, "difficulty in having to keep on calling those people and probing them and prompting them to help. I had to keep calling. I also experienced difficulties with the home care I used to get. Every other day I had a different home care worker. I had to settle with

this one."

Not surprisingly, the other women interviewed were not satisfied with the assistance they received from the CASA worker assigned to help them. None of the women who were Medicaid Pending even knew who their CASA worker was, even though CASA workers are mandated to make home visits to all Medicaid applicants in need of home care services. Of the women who already had Medicaid, three-quarters were dissatisfied with the assistance they were receiving.

Mona described her CASA worker as "mediocre. He's just a mediocre person. I don't know how the devil they get these jobs. They just go through the system. It's sad, very sad." Kitty said "I don't like any part of them. I'm so discouraged that I don't care."

The other women interviewed were not satisfied with the assistance they received from the CASA worker assigned to help them. None of the women who were Medicaid Pending even knew who their CASA worker was, even though CASA workers are mandated to make a home visit to all Medicaid applicants in need of home care services. Of the women who already had Medicaid, three-quarters were dissatisfied with the assistance they were receiving from CASA.

Strategies that were helpful in obtaining coverage

The Role of the Case Manager

The women who had Medicaid were asked what they thought seemed to help them obtain Medicaid. All four women said that their case manager from Project SCOPE helped them to overcome the obstacles they encountered and helped them to access Medicaid coverage. Pamela said that what helped, "was knowing what to do, to give the proper paper that was requested. And of course, she was a good helper, Ms. Maxine [her case manager]. I tell you that your agency and other agencies perform wonderful work in helping."

For Mona persistence on the part of her case manager and herself was helpful, "Persistence, persistence, persistence, by myself and Diane [case manager] is what helped me get Medicaid."

Debra described her application process as "very simple, as a matter of fact, Rachael [case manager] made it very simple. And I think my daughter filed a few papers." Agnus also said that her case manager made the application process a pleasant experience. " Silvia [case manager] was very nice, a lovely person. She was understanding and so on and so forth. The experience was very pleasant because of her. She was very nice, very sweet."

Role of Hospitalization

In addition to the assistance from their case manager, Kitty's daughter said that the "information sheet from the hospital" helped her to gather the papers needed by Medicaid for her mother. Interestingly, all four women who had Medicaid had been hospitalized during the application process. Further study would indicate what influence, if any, hospitalization had upon their access of Medicaid. Practice knowledge would suggest that access to Medicaid would be faster for women who were hospitalized as the hospital would have an interest in assisting the applicant so that they would get reimbursed for the hospitalization. As advocate findings suggest (Chapters 4 and 5), access to Medicaid was faster and less difficult for hospital-based advocates as well.

Level of satisfaction with Case Management Services

Receiving case management services through a community-based organization was also described as very helpful for these women in gaining access to Medicaid. In contrast with their dissatisfaction with CASA's assistance, the women interviewed said that they were very satisfied with the help they received from their case managers at Project SCOPE. Debra described the assistance she was receiving as, "excellent. Really excellent, very caring, very interested, warm. She's really been a really helpful person." Pamela also described the assistance she received from Project SCOPE as, "excellent, and very much interested in my welfare. It has given me a great sense of security, which is what I need." Mona described the

help she received as, "Great. Great person. Very warm, very homey, a real person, a good person. Kitty said, "No problem, no complaint. She has gone completely out of her way to help. And when I have to talk this way it is a sad state of affairs." Finally, Agnus said, "Very, very good. Very good."

Quality and Use of Medical Services

In contrast to their dissatisfaction with CASA's assistance, the women interviewed were generally optimistic about the quality of medical care they would receive under Medicaid's coverage. All women were asked if they thought that the quality of medical care they would receive through Medicaid coverage would be worse than the quality of care they were receiving. Out of eight women only one woman, (who was pending Medicaid), thought that the quality of care would be worse. Those who had Medicaid did not think that the quality of medical care would be worse than what they received before they were covered by Medicaid.

However, having Medicaid coverage many have some influence upon the frequency of physician visits for older women. When asked how often they saw their primary care physician, there were differences in frequency between those who had Medicaid and those who did not. The women who did not have Medicaid, on average, saw their physician more often than the women who had Medicaid coverage. Those women who did not have Medicaid saw their primary care physicians an average of once a month (12/year). Those with Medicaid

saw their physicians half as often--an average of once every two months (6.5/year). This finding may suggest that Medicaid providers, who are traditionally reimbursed less per patient visit, may not do not see their older female patients as frequently as medical providers who accept Medicare or other insurance as the first payer. As this finding is based upon a very small sampling of individuals, further research may reveal differences in the quality and quantity of medical care between those covered by Medicaid and those covered by Medicare.

Having Medicaid Coverage

Satisfaction with Medicaid

The four women who had Medicaid coverage at the time of the interview were asked how they felt now that they had Medicaid, and if having Medicaid had changed their use of medical services in any way. Their responses were very mixed. Pamela described having Medicaid as very comforting to her. For example, Pamela said, "I feel much rested. It gives me peace. I came out of the hospital one month ago. I have not had any bills, because I have Medicaid, and they have my number. Having Medicaid coverage means peace, inner peace, which is good for someone who has a bad heart."

Agnus also had a positive response to the same question. "I feel great, because I won't have to pay my Blue Cross Blue Shield. I won't have to pay everyone $200, that's it. It means I'll have a little help, anyway."

When asked if having Medicaid changed their use of medical services in any way, two of the women gave examples of how having Medicaid had positively helped them. Pamela said, "All my doctors are at one hospital." In addition, she stated, "Now I have more home care, that was at my doctor's request." Agnus explained that now she has Medicaid she does not have to pay for her medication. "I still take the same medications. I used to have to pay for my medicines and now I don't have to pay for my medicines."

In contrast, the responses from Mona and Kitty indicated a lack of satisfaction with their coverage. They felt they had no choice but had to accept Medicaid because they needed its covered services. "I don't like it. I don't like it at all, because you have to answer to people. You have to tell your whole life history. We have strangers in this country who are getting the red carpet treatment, while the people who are born and bred here, have to scrape the bottom of the barrel," said Mona.

"It is something I need. I have to do it. There is nothing else I can say about that . I have no choice. Kitty said, "I told you before--it stinks with capital letters. Everyone takes money. It stinks with capital letters. Since I've had Medicaid, I've had less care. The service stinks."

Words of Advice

In concluding the interview with the women who had Medicaid, they were asked if they had any "words of advice for other women who were applying for Medicaid." Two women gave

words of advice and encouragement to other women who were considering applying. When asked what words of advice she had for other older women, Pamela recommended having an advocate to help. Pamela said, "Have a devoted social worker, and a knowledgeable one. In other words, someone who cares. Because that's what it takes. It was a long stretch, full of requests, but we made it, thanks to Nancy [case manager] and her knowledge."

Agnus encouraged other women to try to get Medicaid, even though it was a long, difficult process. She said, "It's very hard to get, that I know. That's about all. Try, you can only try. Try until you get it."

In contrast, Mona suggested that they not apply if at all possible. "If you can help yourself, don't apply. Don't do it. If they can keep themselves going without Medicaid, it would be better. If they have choices, it would be better for them not to apply. The people [Medicaid Administration] have no feelings. They don't get involved. Something is missing."

Unanswered Questions: Lack of Information

Some of the women interviewed asked several questions which revealed their lack of information regarding Medicaid coverage. Mary, who was pending Medicaid approval, asked me a question about the Medicaid process. Asked Mary, "Maybe you can answer a question for me. I know that I have to give up all my money [not true] and I'll get some help in the home. What I want to know is, who pays for my groceries? I'm confused about what

Medicaid is all about. I don't always get definite answers about my questions."

Mary was under the incorrect assumption that once she obtained Medicaid coverage she would have to turn over all of her monthly income to Medicaid. She did not understand that under the surplus Medicaid program she would be asked to pay her home care agency only a portion of her income. Mary's question about who would pay for her groceries reflects her lack of knowledge about the Medicaid program in general. In addition, her question may reflect her underlying anxiety about her future economic welfare, and ability to manage financially while on Medicaid.

Debra, another Medicaid applicant said, "I'd like to ask you, what about my possessions? Who will get them?" It appears that Debra did not know if she would be able to keep her material possessions, or if the Medicaid administration would take these from her once she was on Medicaid.

The above questions suggest that it would be helpful for case management staff to make sure that their clients are well educated and informed about Medicaid coverage and its potential impact upon them. These clients' misconceptions indicate that some elderly Medicaid applicants are not fully educated about Medicaid, and are confused about the impact Medicaid would have upon their future economic well being. In the last chapter, recommendations for practice will address this client-based concern.

Conclusion

In summary, the primary motivation to apply for Medicaid for these women was based upon their need for home care and medically related services including medication and hospitalization, not fully covered by Medicare or their medigap policies. All expressed ambivalent feelings about applying for Medicaid, but applied because of their need for its covered services. Fears of the stigma, loss of independence, and lack of information regarding eligibility appeared to influence when these women actually applied.

During the application process several obstacles were encountered. For these women, their case manager appeared to serve a helping role in assisting them in overcoming these obstacles, especially in respect to the need for documentation. In addition, the case manager appeared to protect, or shield the client from experiencing some of the bureaucratic difficulties commonly experienced by advocates. Overall, the women who had Medicaid were satisfied with the quality of their medical and home care services, but were dissatisfied with the assistance they received from their CASA workers. In the following chapter, recommendations for policy, practice, and training will be presented.

Chapter 8

Conclusion: Recommendations for Training, Practice, and Policy

Introduction

In this final chapter, findings from both advocate and client questionnaires will be applied to practice. In particular, recommendations for training, direct practice, and policy will be made. The recommendations to follow, which are based upon practice with the elderly, may also be helpful for advocates assisting other client populations (e.g., persons with AIDS). In addition, although these recommendations for practice are based upon research on Medicaid, these suggestions may also be applicable to advocates when attempting to access other entitlements (e.g., food stamps).

Recommendations for Training

Analysis of advocate findings indicated that many advocates were not sufficiently trained to efficiently access Medicaid. Lack of sufficient training may contribute, in part, to the lengthy Medicaid application process found. Findings from the high volume subset of

advocates indicate that advocates who spend most of their work-related time accessing Medicaid are able to access Medicaid more efficiently. These advocates were able to access coverage within the shortest time spans and with the least amount of difficulty. From these findings, we can infer that training and practice experience have a direct positive influence on the ability to access coverage.

Development of a "Hand's-on" Training Manual

Based upon this research study, I would like to make several recommendations for training. First, I would like to recommend the development of a "hands-on" advocate training manual for social workers and other professionals who are involved in accessing Medicaid and other entitlements. This manual would be based, in large part, upon the strategy suggestions made by the advocates of this research study (see Chapter 6).

This "hands-on" training manual would evolve from the direct practice of the advocates sampled. When necessary, other advocates' strategy suggestions would be incorporated. To the fullest extent possible, this manual would be a generic advocate's manual, containing suggestions and strategies for how to be a good advocate. In addition, this training manual would have specialized sections for specific entitlements, such as Medicaid, food stamps, etc. The manual would contain such recommendations as: how to document eligibility, how to keep good records, how to develop collaborative relationships, and so forth (refer to Chapter 6).

Establish Training Seminars

In addition to the development of an advocate's training manual, I recommend the development and use of quarterly, or semiannual advocates' training seminars. Using experienced advocates as the trainers would help ensure that their practice knowledge is imparted to the larger advocate community. Specifically, I recommend a training team comprised of hospital-based advocates (and/or other high volume workers) and elder care attorneys, who would conduct full day training seminars on Medicaid. These practitioners are recommended because of their high degree of experience and proficiency, and because of their knowledge of Medicaid policies and regulations. I suggest that this training be partially sponsored by the individual borough-wide Medicaid Advisory Councils. Such sponsorship would help ensure support and collaboration from the New York City Medicaid administration, which would prove valuable in imparting information and intervening in difficult situations.

In-house Medicaid Specialist

I recommend that community-based organizations who process lower volumes of Medicaid applications select one to two persons per agency who would serve as their in-house Medicaid specialist(s). This recommendation is based upon the finding that advocates who process higher volumes of Medicaid applications are more proficient and effective in their efforts (see Chapter 5). Having an "in-house Medicaid specialist"will

allow smaller community-based agencies to more efficiently use their limited staff time. Rather than having several staff members process their own clients' Medicaid applications, one staff person would be designated to process applications on behalf of the agency. Depending upon the size of the agency and the volume of Medicaid applications, this staff person could possibly assist with other entitlements as well. Through increased experience, such an "in-house" specialist would become more knowledgeable and proficient. Smaller community-based organizations might want to share staff resources and costs, having one specialist assist more than one organization simultaneously.

Use of Pre-screening Training

In addition to the above recommendations, I suggest that agencies and organizations take full advantage of the pre-screening opportunities currently offered by the Medicaid Administration. Sponsored by Medicaid, pre-screening is an opportunity for advocates to receive basic training in preparing Medicaid applications. In addition, following pre-screening training the advocate would be able to schedule initial appointments for Medicaid applications at the central Medicaid office, as well as at the satellite offices in municipal hospitals throughout the city. The use of these satellite Medicaid offices is highly recommended. Community-based advocates are advised to use these sites as often as possible. Unfortunately such pre-screening appointments are only applicable for Medicaid applicants who are applying for "straight-out" Medicaid (applying for Medicaid coverage only), and not for Medicaid-funded home care applicants.

Use of Medicaid Conferences and Fair Hearings

I recommend that advocates be trained to use the Medicaid Conferences and Medicaid Fair Hearings offered by the Medicaid Administration. While Medicaid Conferences do not ensure legal protection of an applicant's right of appeal, they can be very helpful in resolving some eligibility related issues. An advocate can usually schedule a Conference within a week or two, compared to a several months' wait for a Fair Hearing. In addition, the atmosphere of a Conference is more collaborative, and less adversarial than a Hearing.

Advocates are advised to use Medicaid Fair Hearings whenever the legal rights of the applicant must be protected, and when a Conference would not be appropriate to resolve the eligibility determination. As indicated earlier, Medicaid Fair Hearings can be used to protest Medicaid's determinations for eligibility and home care service authorization. Requesting a Fair Hearing with 'aid continuing' will preserve home care (and other Medicaid-funded care) at least until the Fair Hearing has concluded.

Advocates need to be trained when and how to use a Fair Hearing. When a Fair Hearing is appropriate, advocates should be especially well prepared for the Hearing. The collection of substantial documentation to demonstrate eligibility for Medicaid (and, if appropriate for other services) should be extremely well organized and abundant. Advocates should be prepared to provide a full array of information in response to Medicaid's questions during the Hearing. In the recent past, (past twelve months), Medicaid workers have been more

prepared and successful than usual, in their ability to win Fair Hearings. This is a marked change from the past when they would often fail to show up, or would arrive without the client's case file, etc. This change may be directly attributed to efforts on the part of the Medicaid Administration to reduce its budget, in part by denying eligibility when not documented adequately. As a result of this change, advocates should take additional care to be well prepared in order to present their case at the Hearing. Consultation with elder-care attorneys and other professionals is also highly recommended.

Recommendations for Practice

Recommendations for practice are based upon this researcher's study on access to Medicaid for older women. However, the following practice recommendations may also be applicable for practitioners who work with other age and special needs groups. In addition, these practice recommendations may be applicable to some degree in accessing other entitlements. The reader is encouraged to consider additional applications for these practice-based recommendations.

Taking a Proactive and Responsive Role

The practitioner is encouraged to take a proactive and responsive role in all advocacy efforts when obtaining this entitlement. A proactive role, in this context, is one in which the advocate takes an active role in obtaining up to date information related to the access

of Medicaid. Taking a proactive role will give the advocate an opportunity to anticipate problems before they occur, and to appropriately plan a strategy of intervention when necessary. The advocate should also develop methods, and protocol to respond to difficulties when they do occur. Maintaining a proactive and responsive stance is recommended to help assist the practitioner to more effectively advocate on the behalf of the older client. The advocate is also advised to take a proactive role in collaborating with other professionals, especially with the Medicaid administration. Establishing collaborative relationships with key individuals (i.e., CASA/Medicaid directors, bank managers, etc.), will enable the advocate to more easily overcome access barriers when they occur.

Participation in Medicaid Advisory Councils

As indicated earlier (Chapter 3), the richest data on accessing Medicaid was obtained from distributing the research questionnaire at the individual borough-wide Medicaid Advisory Councils (MAC). On average, individuals who attended these meetings tended to have greater experience and practice knowledge related to accessing Medicaid, than those who did not participate in MAC's. In fact, the high volume advocates were highly represented among MAC participants. By attending MAC's, practitioners will be able to obtain up to date information regarding Medicaid eligibility policies and regulations. Because there are limits to the size of each Council, not all interested practitioners will be able to serve as part of the Medicaid Advisory Councils. Therefore, on a local community basis, each community district could have its own MAC representative. This

representative could in turn impart information, either through circulating minutes of council meetings, or by reporting at monthly Inter-Agency Council (IAC) meetings within the local communities.

Become a Knowledgeable Advocate

As the advocates in this study indicated, being a knowledgeable advocate is vital for effectively accessing Medicaid. Wrote one advocate on the importance of good advocacy, "I think that almost anyone can get Medicaid (providing they are eligible), if they have good advocacy. I think many people may not be able to get coverage simply for lack of a good advocate--someone who can negotiate the system for the client."

In order to be a good advocate practitioners are encouraged to try to keep up to date on all available information regarding Medicaid eligibility, regulations, and policies. As the future of Medicaid-funded services, especially in New York City, will be undergoing numerous changes in response to budgetary constraints (on Federal, State, and City levels), it will become more important than ever for the advocate to keep abreast of upcoming changes. Practitioners are advised to participate in local and city-based inter-agency councils, subscribe to entitlement-related newsletters, and to participate in the borough-wide Medicaid Advisory Councils, as ways in which to keep up to date on eligibility and policy changes.

Establish Advocacy Networks

Another recommendation for practice is the establishment of community-based advocacy networks within the elder-care community. Through the use of already established ongoing Inter-Agency Councils (IAC's) and other similar forums, elder care advocates could devote some meeting time for the exchange of advocacy related information, or could devote one or two meetings per calender year for the discussion of entitlement and advocacy information. Advocates who do not regularly attend these meetings could still benefit from reading minutes and handouts from agency representatives who attend. Establishing the opportunity for the exchange of such information will help ensure that a greater number of elder-care advocates are knowledgeable and current about Medicaid policies and regulations. Such a forum could also provide an opportunity for any political or advocacy related efforts.

Direct Practice Recommendations

As indicated in Chapters 5 and 6, advocates described a number of specific strategies which they considered effective for accessing Medicaid for their clients. I recommend that these access strategies be utilized by practitioners whenever applicable, and that advocates evaluate their effectiveness for individual client situations. As these strategy recommendations are based upon a sizable sampling of elder-care advocates (N=102), it is assumed that these strategies will be effective in the majority of cases. However, the

practitioner is urged to utilize professional discretion and judgement in application of all practice strategies.

Identification of Specific Strategies

Access strategies include recommended strategies for: encouraging eligible clients to apply for Medicaid; how best to prepare the Medicaid application; submit documentation; track the application after submission; and how to collaborate most effectively with Medicaid personnel and administration. A brief outline and discussion of these strategies will follow. The reader is advised to refer to Chapters 5 and 6 for greater explanation and detail.

Encouraging Eligible clients to apply for Medicaid

When working with an elderly client who is Medicaid eligible, but has not yet decided to apply, several practice strategies are recommended. Practitioners are encouraged to stress the helpfulness of Medicaid to the potential applicant. Advising the client how Medicaid would provide financial benefits for them-- through the provision of medical services they currently are paying for out of pocket-- will help encourage eligible clients to consider applying. In addition, explaining how Medicaid could help the client to remain in their own home, while receiving Medicaid-funded services, is recommended as an incentive to help encourage potential applicants. Stressing the cost-effectiveness of receiving Medicaid-funded services (home care, prescription drugs, etc.) may help encourage eligible clients to

apply. In addition, using reasoning and reframing to help reduce clients' fears and the stigma often associated with Medicaid are also recommended. Reframing Medicaid in a similar way to Medicare (client tax dollars have helped finance both), is recommended as a strategy to help reduce the stigma associated with Medicaid.

While encouraging eligible clients to apply for Medicaid, I also recommend that the practitioner provide the client and/or their family full information on Medicaid eligibility policies. Based upon the client interviews described in Chapter 7, the need for additional client education is indicated. Several of these applicants had incorrect information about what would happen to their possessions and other assets after they received Medicaid coverage. Clients need to have full information regarding Medicaid eligibility and policies in order to make an informed decision about their application.

Preparing the Medicaid Application

Involving the client and their family (if possible) throughout the entire application process is recommended. In preparing the application, the family or significant others may be very helpful in locating necessary documentation. The involvement of the client and/or family members is encouraged to foster the helping relationship between practitioner and client, and to help expedite the location of documents and other information.

Specifically, the use of preprinted checklists, and clear indication (through the use of large

dark lettering) of exactly which documents are needed by the client and/or family are recommended to help obtain the individual documents needed for the application. In addition, the advocate should make sure that all requests for documentation are clearly understood by the client and/or family member(s), to avoid confusion and delays later on.

If specific documents cannot be located, the advocate is advised to involve the client and/or family in writing a letter of explanation (e.g., a spouse's death certificate from a foreign country). In addition, the advocate is advised to anticipate Medicaid's questions regarding any unusual circumstances (e.g., spousal refusal, transfer of assets) and to provide a full explanation at the time of initial application to avoid a deferral and other delays. Developing relationships with administrators at local Social Security offices, Department of Vital Statistics, and local bankers is also recommended to help the advocate obtain needed documentation in a more timely manner.

Submitting and Tracking the Application

Excellent record keeping on the part of the advocate is an essential part of the application process. Making duplicate, even triplicate copies of all documentation submitted is necessary because of the high probability that some of these documents will get "lost" after submission. In addition, hand or special delivery of the Medicaid application, and obtaining a signed, dated receipt for the application and all related documentation is recommended. The use of Federal Express, overnight postal delivery, and registered mail

(return receipt requested) are recommended for ensuring timely delivery of the application and documentation.

In tracking the application after submission several strategies are recommended: consistent phone contact; developing collegial relationships; utilizing the chain of command; and obtaining direct access of information. In each of these efforts, good record keeping and collegial relationships with Medicaid personnel will likely be very helpful in ensuring access to Medicaid.

Developing Collegial Relationships with Medicaid/CASA

Throughout the advocate recommendations, the development of good collegial relationships with Medicaid/CASA personnel was consistently mentioned. Cultivating and maintaining good collegial relationships with personnel at Medicaid/CASA is recommended to help advocates more effectively access Medicaid for their clients. Advocates recommended offering support, assistance, and validation to these staffs as ways to begin to cultivate and develop good working relationships. In-person meetings, the sharing of resources and client related information are also recommended to help develop a good collaborative relationship. When appropriate, informal or casual encounters may also be helpful in maintaining these collegial relationships. The establishment and maintenance of such collegial relationships are not only recommended for helping to access Medicaid coverage, but may also prove invaluable in resolving

difficult service-related issues in the future.

Professional Use of Self

In accessing Medicaid, as in performing most other client-related goals, the worker's ability to sustain professional use of self is highly recommended. Maintaining emotional composure throughout all advocacy efforts is recommended to help ensure good relationships and effective collaboration. Advocates are advised to be professional and cordial, yet persistent in all efforts. It is also advised to avoid an adversarial posture whenever possible.

Use of the Legal System

Despite the best efforts of the advocate, at times it may be necessary to utilize the legal system in order to obtain access to Medicaid for some clients. Advocates should use their professional judgement in determining when consultation with an elder care attorney or other legal practitioner (e.g., Legal Services for the Elderly) is indicated.

The Role of Supervision

In direct practice, the role of supervision is important for overseeing the recommendations of training and practice. It is the supervisor's responsibility to make sure that individual

client advocates are adequately trained and supervised in their advocacy efforts. To do so, the supervisor should also be well versed and knowledgeable in accessing Medicaid and related care services. Staff should be permitted the opportunity to attend training and advocacy-related events to further their knowledge base and networking connections.

Practice Wisdom

In the words of several advocates are "practice words of wisdom," offered to help other practitioners:

"Don't trust the system to work properly, but hold it to the established guidelines and time lines. Know the process, prepare your clients so they will be tenacious. Let them know the reality of the 'system' so they will not be disappointed and drop from the process. Keep on top of Medicaid workers, let them know the client is not 'anonymous,' but known, and will not be forgotten."

Wrote another advocate, "Dealing with the system can be frustrating and time consuming, but the benefits are important to many clients. Pursue the application aggressively. Be a squeaky wheel. It does get the grease. Where you see systemic problems, bring them to the attention of the upper management. This often yields positive results."

Stated another about the application process, "It's a difficult process which requires

extensive knowledge and training, which many people doing applications do not have. Be very thorough, careful, and smart regarding what you write and how it will be taken by Medicaid."

Recommendations for Policy

Policy recommendations are based upon research findings and practice-related experience. The current fiscal problems related to the national and local Medicaid budgets are attributed, in part to the lack of a national health care policy which would incorporate financing for long term care. In addition, New York State's broad eligibility criteria (State Comptroller, 1989) have impacted upon this state's Medicaid budget. On local levels (New York State and City), Medicaid's budgetary problems appear related to inconsistent eligibility policies and a poorly designed service delivery system. Within this system unnecessary coverage is granted, while the truly needy are often excluded. Recommendations for policy, organizational redesign, and service delivery will be presented to address these issues.

The words of one advocate provide a brief illustration of some of the policy-related problems of Medicaid, "I believe the system definitely needs an overhauling with regards to its service policy (to provide better checks and balances), for example, who should and should not be receiving services at any age category. I truly believe this would help cost containment and allow for more efficient service delivery."

Impact of the Current Political Climate

The current political climate on a National and State basis' is set to significantly reduce the national deficit. Medicaid expenditures on all levels--nationally, New York State, and New York City are extremely high. Presently there is significant political pressure to reduce Medicaid costs locally, and to reduce Federal funds to the States for Medicaid. As a result, New York State is currently poised under a new Republican Governor to drastically reduce the Medicaid budget in New York State, and especially in New York City.

Because the majority of all New York State Medicaid dollars are currently expended in New York City, the City has been targeted for the most substantial cuts. Home care service in New York City is the prime target for these draconian budget reduction measures. As a result, the future of Medicaid funded home care services is presently in jeopardy. Home care advocates will be politically active in the coming months in an attempt to reduce the severity of the proposed cuts to Medicaid-funded home care services. The most recent proposal was for a capitation of no more than 25 hours of home care service per client per week. Individuals needing more than 25 hours would be advised to seek nursing home care. As there is also a proposed moratorium on building or expanding nursing homes, the impact of these service restrictions will be devastating. Those at greatest risk are the most frail elderly without available family or other support systems.

Moving frail elderly into nursing homes will do little to reduce the high costs of Medicaid for long term care in New York State and City. The average monthly cost of providing around the clock is estimated to be $2,500-$3,000 (including rent, food and other household expenses), compared to an average of approximately $6,5000 for nursing home care. Clearly such a policy will not create savings. Minimally skilled home care workers, who will no longer be employed in the Medicaid funded home care industry, may be forced to apply for public assistance. While this may appear to create reductions in overall Medicaid home care service costs, there will be a resulting swell in public assistance benefits (including Medicaid coverage for these former home care workers). Those who will be at greatest risk will be frail elderly who will have difficulty managing with 25 hours of care per week. As there is likely to be a shortage of care givers for the elderly (Soldo & Manton, 1985), many of these frail elderly will be left alone for the majority of the time. It is estimated this will create an increase in malnutrition, hip fractures, and other costly medically related problems.

The Home Care Council of New York has proposed a number of ways in which to reduce the New York State Medicaid budget--specifically, they propose to accelerate a number of cost containment measures which have already been initiated--Cluster Care, the use of Personal Emergency Response Systems, and the Electronic Time Sheet System. Each of these measures is designed to reduce home care service costs to the State. These cost containment measures have already demonstrated cost savings without increasing undue risk to clients.

Reduce Legal Loopholes

There are several legal loopholes regarding Medicaid eligibility which have helped increase the deficit in New York State's Medicaid Budget. Specifically, the transfer of assets guidelines and the spousal refusal provisions enable individuals to qualify for Medicaid coverage who would otherwise be clearly ineligible.

Under the transfer of assets provision, Medicaid home care applicants are able to impoverish themselves by transferring their surplus financial assets to family or friends, and then subsequently apply for Medicaid. In my opinion, this provision has contributed, in part, to larger numbers of the non needy individuals obtaining coverage. Without the transfer of assets law, some individuals would clearly be ineligible for Medicaid. The transfer of assets provision has perpetuated the recent trend of Medicaid becoming the "Long term health insurance for the middle class."

Similarly, the ability of nursing home applicants to transfer their assets enables additional individuals to qualify for Medicaid. Following established penalty periods of ineligibility, depending on the amount and time of the transfer, applicants who could well afford to pay for care themselves are able to qualify for Medicaid coverage. The transfer of assets provision enables the middle class, and even the wealthy class, to apply for Medicaid assistance, placing a financial burden upon the public tax payer.

Current Medicaid policies enable either party in a marriage to declare "spousal refusal." The term "spousal refusal," refers to one spouse's declaration that he/she can no longer provide financial support for the partner's medical care expenses. Under current policy, either spouse can declare refusal of support, in turn enabling the other spouse to apply for Medicaid if their individual finances are within Medicaid guidelines. By separating joint assets, one member of a married couple can obtain Medicaid coverage, while the remaining spouse may maintain significant financial resources. These legal loopholes not only contribute to larger numbers of individuals receiving coverage, but in turn contribute, in part, to the backlash against the truly needy Medicaid recipients.

Organizational Redesign for New York City Medicaid

Noncompliance with Federal Mandates

Findings from advocate questionnaires suggest that New York City's Medicaid administration is frequently out of compliance with Federal guidelines regarding eligibility determinations. Federal mandates state that determinations for Medicaid eligibility must be made within 30 days of initial application. As the advocate findings indicate, on average, determinations were made in excess of two months-- clearly out of compliance with this mandate.

Advocate findings also reveal a number of organizational barriers to providing eligible

clients to access Medicaid. These barriers include a lack of adequate training of Medicaid personnel, lack of adequate staffing-- resulting in high case load size and difficulty accessing caseworkers-- and poor work-related attitude.

Training and Policy Recommendations for Medicaid Personnel

Recommendation is made for Medicaid personnel to receive more comprehensive, or at least adequate, training on guidelines and procedures. Lack of adequate training has resulted not only in barriers to care for eligible recipients, but may also contribute to inaccurate eligibility determinations. Inadequate training may contribute to poor work related attitude as well. I recommend that as a part of their training, Medicaid personnel be encouraged to work more collaboratively with other professionals, avoiding an adversarial posture.

Establish Cost-Efficient Service Delivery Systems

Recommendation is made for the redesign of various organizational components of the Medicaid administration in order to make access to care more effective and cost-efficient. The current organizational structure does not adequately support the timely delivery of care to eligible clients. Delays are caused, in part by the inability of different departments to communicate directly with each other. For example, when a client applies for Medicaid and home care services simultaneously, eligibility for Medicaid is determined by one

office, and evaluation of need for home care services are made by another office. Workers from these two different offices are not given direct access to each other--resulting in lengthy determination delays for the client. The inability of these two offices to communicate directly with each other may also lead to poor communication and poor work-related attitudes. The client and advocate are left caught in the middle of this bureaucratic maze.

I recommend that these two functions be carried out by the same office at Medicaid. Or, a more cost-efficient model would be for New York City Medicaid to contract out some of these functions to nonprofit community-based organizations. Eliminating the CASA system of service delivery would not only make service delivery more efficient, but would save money. Using a community-based model, each community district could have its own "CASA," which would evaluate eligibility for Medicaid and home care services. The sponsoring organization would operate within financial capitation criteria as an incentive to contain costs, yet would have the responsibility for adequately evaluating clients for home care services, or assisting with nursing home placement if necessary. These community-based CASA's would work closely with the home care vendor's agencies within their communities, further enhancing the collaborative delivery of services to clients. Organizing the delivery of services under the direct supervision of community-based nonprofit groups may help to reduce some of the organizationally based barriers to service described previously.

Make Application Process User-Friendly

I recommend that the Medicaid application process be revised or adapted for the elderly and other frail client populations. The present application process does not take into account the difficulties of some older persons in locating needed documentation, e.g., obtaining a birth certificate for a 96-year-old who was born in a foreign country may be next to impossible. If the person is a Medicare recipient, as are most individuals over 65 years of age, this should be sufficient to document age. Other documentation requirements could be revised or adapted for elderly applicants as well (e.g., large print information and correspondence). Document requests should be revised to help elderly applicants whose memories are poor. Medicaid should also give more time from the notification of the need to the deadline for document submission.

Establish Rent Exemption Guidelines for New York City Residents

Another policy recommendation for responding to the needs of the elderly New York City Medicaid applicants would be to establish a realistic rent exemption policy. According to current application guidelines there is no exemption for the disproportionally high rents (compared to monthly income) that some New York City Medicaid applicants may pay. When applying for Medicaid some individuals, who qualify for Medicaid surplus, are forced to choose between paying their monthly Medicaid surplus and paying their rent and food expenses. Obviously, the majority opt for meeting their basic needs first, and ignore

their Medicaid surplus. As home care agencies currently cannot refuse to provide home care services to such individuals, the home care agency is forced to provide services within an operational deficit. Establishing a realistic rent exemption policy, which would reflect the New York City rental market, would allow many Medicaid home care clients to receive coverage without detriment to their home care providers.

Summary

This study was originally designed to identify the obstacles and facilitators of access to Medicaid for older women. The study was not designed to reveal gender differences about access, however advocates are asked about their perspective to this issue. While gender was not found to directly influence access for Medicaid, based upon this limited study it cannot be ruled out as an influencing factor. The study's primary focus evolved in response to advocate findings to reveal important access strategies from the advocates' perspective.

Practically significant for advocates and clients are the researcher's recommendations for training, practice, and policy developed through this study. Future research on this topic may include studying the obstacles to access (and facilitators as well) from the perspective of the Medicaid worker. Obtaining an insider perspective on the problems of this large bureaucratic organization could yield interesting recommendations for organizational redesign.

Appendix 1

Research Instruments

ADVOCATE PERSPECTIVE ASSESSMENT Code#_____

Informed Consent

I,_____, give permission to Rebecca Mushkin to review this questionnaire for research purposes. It is my understanding that the information obtained will be confidential and will be used for research purposes only. I understand that in no way will my name be used without my informed consent. My participation or lack of participation in this interview will in no way affect any of the services my clients receive through the Lenox Hill Neighborhood Association or its affiliates.

_____ _____

signed date

Introduction:

I am a student at the Hunter College School of Social Work where I am doing research for my doctoral dissertation. I am interested in identifying both the obstacles to and the facilitators of Medicaid coverage for older women (65+ years of age). I would like you to answer a number of questions about yourself and your experiences advocating for older women in the Medicaid application process. Unless stated otherwise, all questions pertain to assisting older women obtain access to Medicaid. Please try to answer each question to the best of your ability. Your answers will be confidential and will be used for research purposes only. Thank you for your participation. If you have any questions please contact me.

Rebecca Mushkin, CSW, Director, Project SCOPE,
Lenox Hill Neighborhood Association
331 East 70th Street, New York, NY 10021 (212) 744-5022, X209

Dear Colleague:

Thank you for your assistance in completing the attached questionnairre. I am a doctoral student at the Hunter College School of Social Work where I am conducting research for my dissertation. I am interested in identifying both the obstacles to and the facilitators of Medicaid coverage for older women (65+ years of age). I am interested in finding out what your experience has been in assisting older women obtain Medicaid. I would like you to answer a number of questions about yourself and your experiences advocating for older women during the Medicaid application process.

Unless stated otherwise, all questions pertain to assisting these women obtain initial approval for Medicaid. Please try to answer each question to the best of your ability. Feel free to attach additional sheets if necessary. Your answers will be confidential and will be used for research purposes only. The goal of this study is to develop policy, practice, and training recommendations for accessing Medicaid. Thank you again for your participation in this study. If you have any questions please contact me.

Rebecca Mushkin

Rebecca Mushkin, ACSW
Director, Project SCOPE
Lenox Hill Neighborhood Association
331 East 70th Street, New York, NY 10021
(212) 744-5022

Please tell me about yourself:

1. Age____

2. What is your gender?

____female

____male

3. With which racial/ethnic group do you identify yourself?

____Caucasian

____African American

____Hispanic

____Asian

____Other, specify_____

4. What is the highest level of education you completed?

____BA

____BSW

____MSW

____JD

____DSW

____other, specify_____

5. How many years have you worked in social/legal services? ____(years)

6. How many years have you worked with the aged? ____

7. Where do you work? **Chose the category which best describes your place of work.**

____Aging Services--Public (not-for-profit)

____Aging Services--Private (for profit)

____Hospital/Health Care Clinic

____Home Care Agency

____Community Based Organization

____Residential Health Care Facility

____Settlement House

____Legal Services

____Mental Health Services

____Other, specify

8. What is your title?_____

9. Which best describes your function? Chose the category which best describes your function.

____Direct Practice

____Supervision

____Administration

____Advocacy

____Community Organizing

____Other, specify_____

10. How would you describe the clients served by your agency?

____% Caucasian

____% African American

____% Hispanic

____% Asian

____% other (describe)_____

11. What are the native languages of the clients served by your agency?

____% English

____% Spanish

____% Chinese

____% Other_____

12. On average, how many Medicaid applicants do you assist each year?

_____(fill in number per year)

13. Approximately what percentage of these applicants are female?

_____%

14. Have you noticed any differences in the ability to obtain Medicaid coverage between male and female applicants? ____yes_____no.

If yes, describe the differences you have observed.

15. In your experience do older men or older women have an easier time obtaining Medicaid?

____older men have an easier time

____older women have an easier time

____no difference

If you have indicated a difference, please explain.

16. In your practice, what have you found are the reasons that women who are eligible for Medicaid or Medicaid surplus do not apply:

(Please rank order from 1-most frequent to 4-least frequent)

____Because of the stigma associated with Medicaid

____Because of the difficulties their friends/neighbors encounter with the Medicaid administration

____Because they will have to disclose full financial information in the application process

____Other, describe.

17. Have you encountered difficulties in accessing Medicaid coverage for any of your clients?

____Yes____No. If no, skip to question 19.

If yes, what percentage of the time do you encounter difficulties accessing coverage?

_____%

18. What kinds of obstacles have you encountered when assisting older women in the application process? **Please check all that apply.**

a.____Difficulties tracking the progress of the application following submission to Medicaid?

If yes, in what percentage of cases do you experience this problem?

_____%

b.____Lack of accurate financial information from clients prior to application?

If yes, in what percentage of cases do you experience this problem?

_____%

c.____Difficulties obtaining documentation from clients?

If yes, in what percentage of cases do you experience this problem?

_____%

d.____Requests for client documentation already submitted to Community Alternative Services Agency (CASA)/Medicaid?

If yes, in what percentage of cases are you (or your client) asked to submit documentation already been submitted?

_____%

e.____What other difficulties/obstacles have you encountered while assisting clients in obtaining Medicaid coverage? Indicate in what percentage of cases you have experienced each problem. Attach an additional sheet(s) if necessary.

19. How would you describe the assistance your clients receive from CASA/Medicaid?

___very helpful

___helpful

___neutral (didn't make any difference)

___not helpful (made things worse)

Please describe in more detail.

20. How often have you gone to Medicaid fair hearings in order to assist clients to access Medicaid?

Indicate the number of times in the past year_____.

21. How often have you gone to Medicaid fair hearings because of problems in service authorizations?

Indicate the number of times in the past year_____.

22. How often have you used the Medicaid conference to resolve problems related to Medicaid access?
Indicate the number of times in the past year____.

23. Have you been trained as a Medicaid "pre-screener"? ____yes____no.
If no, skip to question 24.
a. If yes, do you schedule Medicaid application appointments?____yes____no. If no, skip to question 24.
b. If yes, how helpful is the pre-screening appointment in facilitating access to Medicaid for your clients?
____very helpful
____helpful
____not helpful
c. Has being trained as a "pre-screener" given your clients faster access to Medicaid coverage?____yes____no.
If yes, please explain.

24. Please estimate how many hours of your time per week are devoted to assisting clients in obtaining Medicaid coverage_____ (hours/week).

25. How many of these hours (indicated in question 24) are devoted to convincing eligible clients to apply?____(hours).

26. How many of these hours (indicated in question 24) are devoted to helping clients/family gather documentation? ____(hours).

27. How many of these hours (indicated in question 24) are spent photocopying documents? ____(hours).

28. How many of these hours (indicated in question 24) are devoted to written correspondence with CASA/Medicaid? ____(hours).

29. How many of these hours (indicated in question 24) do you spend talking with clients about the progress of their applications? ____(hours).

30. How many of these hours (indicated in question 24) do you spend in telephone contact with CASA/Medicaid? ____(hours).

31. How else do you spend your time helping clients to access Medicaid? Please describe.

32. At what point(s) in the application process do your clients experience the most difficulties? Include reference to request for home care services (M11Q), Medicaid application and documentation, approval for level of services, etc.

33. What strategies have you found helpful in assisting clients in the application process?

a. In encouraging eligible clients to apply, what have you found helpful?

b. In preparing the Medicaid application (documentation, financial information, etc.) what strategies have you found helpful?

c. In submitting documentation to CASA/Medicaid (hand delivery, receipts, etc.) what strategies have you found helpful?

d. In collaborating with CASA, what strategies have you found helpful?

e. In tracking the application once it has been submitted to Medicaid, what strategies have you found helpful?

f. In tracking the application once it has been submitted to CASA, what strategies have you found helpful?

g. What other strategies have you found helpful in facilitating access to Medicaid for your clients?

34. On average, how long does it take to get a client Medicaid coverage?

35. On average, how long does it take to get a client Medicaid funded home care services? (Include time from initial submission of request for home care services to first day of services.)

36. What words of practice wisdom do you have regarding accessing Medicaid?

37. What else would you like to state regarding the Medicaid process? Attach additional sheet(s) if necessary.

Thank you for your time and participation. As a reminder your answers will be held confidential.

Check here_____and complete below if you would like to receive a summary of my research findings.

Name:

Address:

Telephone:

ASSESSMENT INSTRUMENT: APPLICATION PHASE Code#_____

Informed Consent

I,_____, give permission to Rebecca Mushkin to interview me on _____. It is my understanding that the information obtained will be confidential and will be used for research purposes only. I understand that in no way will my name be used. I understand that my participation or lack of participation in this interview will in no way affect any of the services I receive through the Lenox Hill Neighborhood Association or its affiliates. If I chose I may stop the interview at any time.

_____ _____

signed date

Introduction:

My name is Rebecca Mushkin. I am the director of Project SCOPE of the Lenox Hill Neighborhood Association. I understand that you have been receiving assistance from our program. I am a student at the Hunter College School of Social Work where I am doing research for my doctoral dissertation. I am interested in finding out what makes it easier or harder for older women to get health care coverage. I will be asking you a number of questions about yourself, your ideas and opinions. Please try to answer each of my questions to the best of your ability. If at any time you want to stop or take a break please let me know. Are you ready?

Please tell me your:

1. age_____

2. place of birth_____

3. marital status

_____married

_____divorced

_____single

_____widowed

_____never married

4. Whom do you live with?

_____alone

_____with another_____whom?

5. Who are your close family members?

6. Where do they live?

7. What is your religious affiliation?

____Catholic

____Protestant

____Jewish

____none

____other (describe)

8. With which racial/ethnic group do you identify yourself?

____Caucasian

____African American

____Hispanic

____Asian

____other

9. At any time in your life did you work inside or outside of the home?

____yes____no.

10. If you worked, what did you do?

11. For how many years did you work?_____(months/years)

12. Did you start and stop working to take care of your family?

Now I would like to ask you questions about your medical coverage.

13. Do you have Medicare?_____yes_____no.

If no, why not?

14. Do you have Part A? (hospital coverage)_____yes_____no.

15. Do you have Part B? (physician coverage)_____yes_____no.

16. Do you have any other (Medigap) coverage?_____yes_____no.

If yes, which type of coverage do you have?

a. BC/BS_____yes_____no.

b. AARP ___yes___no.

c. Coverage through former employer? ___yes___no. If yes, which?

d. Other coverage___yes___no. If yes, which?

17. On average, how much money do you pay per month out of pocket for medical care not covered by Medicare or your other medical policy, including doctor visits, tests, medicines, etc? (fill in amount)$_____.

18. Are there health care needs that you do not take care of because they are not covered by Medicare or your other coverage? _____yes____no. If yes, what are these?

19. What would you do if you needed medical care or services that Medicare did not cover?

20. Do you ever go without food or other essentials in order to pay your medical expenses?_____yes_____no.

If yes, how often?

21. I understand that you recently applied for Medicaid, what would you say motivated you to apply now?

22. Under what circumstances did you apply for Medicaid? Explain.

23. Have you ever applied for Medicaid before now?

_____yes_____no.

If yes, tell me why?

24. Why didn't you get Medicaid?

25. If you never applied before, why not?

26. What was it like for you to apply for Medicaid?

27. Who helped you decide to apply for Medicaid?

28. When did you apply, how long ago?

29. How do you feel about applying for Medicaid now?

30. What does applying for Medicaid mean to you?

31. How did you go about applying?

32. Have you met any difficulties during the application process? Please tell me about your experience.

33. Please tell me if you agree or disagree with the following statements:

a. "I've worked hard all my life, paid taxes. I feel entitled to all I can get from the government."____agree____disagree.

b." Medicaid is good for those who really need it."

___agree___disagree.

c. "I am applying for Medicaid because my doctor accepts it."

___agree___disagree.

d. "The quality of medical care I will receive when I am covered by Medicaid will be worse than the quality of care I receive now."

___agree___disagree.

e. " I am applying for Medicaid because I really need its benefits."

___agree____disagree.

34. Do you know anyone who is a Medicaid recipient? ___yes___no.

If yes, does their having Medicaid affect:

a. the way you think about them____yes____no.

If yes, explain.

b. the kinds of services they receive____yes___no.

If yes, explain.

c. the quality of services they receive_____yes_____no.

If yes, explain.

35. How would you describe the help you have received so far from the CASA worker (the city social worker)?

35. How would you describe the help you have received so far from the CASA worker (the city social worker)?

36. How would you describe the help you received so far from your case manager at Project SCOPE?

37. Prior to applying for Medicaid, did you transfer any money to your children or other relatives?

38. Prior to applying for Medicaid, did you spend down your savings, sell any stocks, bonds, etc.?

39. Who advised you how to apply for Medicaid?

40. How were they helpful to you during this process?

41. Do you receive help at home now with caring for your home or personal care?____yes____no. If yes, who helps you?

a. Children____yes____no. If yes, how helpful are they?

____very helpful_____helpful____helped very little.

b. Other relatives____yes____no. If yes, how helpful are they?

_____very helpful_____helpful_____helped very little.

c. Neighbors____yes____no. If yes, how helpful are they?

____very helpful____helpful____helped very little.

d. The Caring Neighbor____yes_____no. If yes, how helpful are they?

_____very helpful____helpful_____helped very little.

e. The Educational Alliance____yes___no. If yes, how helpful are they?

____very helpful_____helpful_____helped very little.

f. Private home care___yes___no. If yes, how helpful are they?

____very helpful____helpful_____helped very little.

g. The VNS___yes___no. If yes, how helpful are they?

____very helpful____helpful____helped very little.

h. Any other help? If yes, who helps you? How helpful is this help?

____very helpful___helpful____helped very little.

42. Approximately how many hours of help do you receive each week?_____(hours).

43. Do you receive any of these services?

a. meals on wheels___yes___no. If yes, how helpful are they?

___very helpful_____helpful____helped very little.

b. transportation___yes___no. If yes, how helpful is this service?

____very helpful____helpful___helped very little.

c. EPIC (Elderly Prescription Insurance Coverage)___yes___no. If yes, how helpful is this?

____very helpful___helpful____helped very little.

d. other services? Explain_____. How helpful is this?

_____very helpful___helpful____helped very little.

44. Did receiving the above help influence your decision to apply for Medicaid in any way? If so, please explain.

45. What else would you like to tell me about your experience applying for Medicaid?

46. Once you get Medicaid do you think there will be any differences in your care or services? Please explain.

47. Is there anything else you would like to tell me about your thoughts about applying for Medicaid?

This concludes our interview. I would like to thank you for your time. As a reminder, the information you gave me will be held in strict confidence and will be used only for research purposes.

ASSESSMENT INSTRUMENT:POST-APPLICATION

Code#_____

Informed Consent

I,_____, give permission to Rebecca Mushkin to interview me on _____. It is my understanding that the information obtained will be confidential and will be used for research purposes only. I understand that in no way will my name be used. My participation or lack of participation in this interview will in no way affect any of the services I receive through the Lenox Hill Neighborhood Association or its affiliates. If I chose I may stop the interview at any time.

_____ _____

signed date

Introduction:

My name is Rebecca Mushkin. I am the director of Project SCOPE of the Lenox Hill Neighborhood Association. I understand that you have been receiving assistance from our program. I am a student at the Hunter College School of Social Work where I am doing research for my doctoral dissertation. I am interested in finding out what makes it easier or harder for older women to get health care coverage. I will be asking you a number of questions about yourself, your ideas and opinions. Please try to answer each of my questions to the best of your ability. If at any time you want to stop or take a break please let me know. Are you ready?

Please tell me your:

1. age_____

2. place of birth_____

3. marital status

____married

____divorced

____single

____widowed

____never married

4. Whom do you live with?

____alone

____with another___whom?

5. Who are your close family members?

6. Where do they live?

7. What is your religious affiliation?

____Catholic

____Protestant

____Jewish

____none

____other (describe)

8. With which racial/ethnic group do you identify yourself?

____Caucasian

____African American

____Hispanic

____Asian

____other, specify

9. At anytime in your life did you work inside or outside of the home?

____yes____no.

10. If you worked, what kind of work did you do?

11. For how many years did you work?_____(months/years).

12. Did you start and stop working take care of your family?

Now I would like to ask you questions about your medical coverage.

13. Do you have Medicare?_____yes_____no.

If no, why not?

14. Do you have Part A? (hospital coverage)_____yes_____no.

15. Do you have Part B? (physician coverage)____yes_____no.

16. Do you have any other (Medigap) coverage?_____yes____no.

a. BC/BS____yes____no.

b. AARP ____yes____no.

c. Coverage through former employer? ___yes___no. If yes, which?

d. Other coverage____yes___no. If yes, which?

17. On average, how much money do you pay per month out of pocket for medical care not covered by Medicare or your other medical policy, including doctor visits, home care,tests, medicines, etc.?(fill in amount)$_____

18. Are there health care needs that you do not take care of because they are not covered by Medicare or your other coverage? _____yes____no. If yes, what are these?

19. What would you do if you needed medical care or services that Medicare (or your Medigap) did not cover?

20. Do you ever go without food or other essentials in order to pay your medical expenses?_____yes_____no. If yes, how often?

21. I understand that you received Medicaid coverage within the past 12 months. I would like you to tell me about your experience applying for Medicaid.

22. What would you say motivated you to apply for Medicaid?

23. How long had you considered applying before you actually did?

24. Did you apply for Medicaid because of a specific need? If so, for what?

25. Under what circumstances did you apply for Medicaid? Explain.

26. Did you ever apply for Medicaid before now?
If yes, tell me why?

27. Why didn't you get Medicaid?

28. If you never applied before, why not?

29. What was it like for you to apply for Medicaid?

30. Who helped you decide to apply for Medicaid?

31. When did you apply, how long ago?

32. How long did it take from your initial application to receive Medicaid approval?

33. How did you go about applying?

34. Who advised you how to apply for Medicaid?

35. How were they helpful to you during the application process?

36. What difficulties, if any, did you encounter during the application process?

37. What seemed to help you get Medicaid (assistance from your social worker, family member, etc.)?

38. Did you encounter difficulties because you were asked for documents/papers you could not locate?_____yes_____no. If yes, what kinds of papers were these?

39. What other kinds of difficulties did you encounter? Please tell me about your experience.

40. Prior to applying for Medicaid, did you transfer any money to your children or other relatives?

41. Prior to applying for Medicaid, did you spend down your savings, sell any stocks, bonds, etc.?

42. How do you feel about having Medicaid coverage?

43. What does having Medicaid coverage mean to you?

44. Please tell me if you agree or disagree with the following statements:

a. "I've worked hard all my life, paid taxes. I feel entitled to all I can get from the government."____agree____disagree.

b." Medicaid is good for those who really need it."

___agree___disagree.

c. "I applied for Medicaid because my doctor accepts it."

___agree___disagree.

d. "The quality of medical care I receive covered by Medicaid is worse than the quality of care I received before."

___agree___disagree.

e. " I applied for Medicaid because I really need its benefits."

___agree____disagree.

45. Do you know anyone else who is a Medicaid recipient? ___yes___no.

If yes, does their having Medicaid affect:

a. the way you think about them____yes____no. If yes, explain.

b. the kinds of services they receive____yes___no. If yes, explain.

c. the quality of services they receive_____yes_____no. If yes, explain.

46. How would you describe the help you have received so far from the CASA worker (the city social worker)?

47. How would you describe the help you received so far from your case manager at Project SCOPE?

48. Do you receive help at home now with caring for your home or personal care?____yes____no. If yes, who helps you?

a. Children____yes____no. If yes, how helpful are they?

____very helpful_____helpful____helped very little.

b. Other relatives____yes____no. If yes, how helpful are they?

_____very helpful_____helpful_____helped very little.

c. Neighbors____yes____no. If yes, how helpful are they?

____very helpful____helpful____helped very little.

d. The Caring Neighbor____yes_____no. If yes, how helpful are they?

_____very helpful____helpful_____helped very little.

e. The Educational Alliance____yes___no. If yes, how helpful are they?

____very helpful_____helpful_____helped very little.

f. Private home care___yes___no. If yes, how helpful are they?

____very helpful____helpful_____helped very little.

g. The VNS___yes___no. If yes, how helpful are they?

____very helpful____helpful____helped very little.

h. Any other help? If yes, who helps you? _____

How helpful is this help?

____very helpful___helpful____helped very little.

49. Approximately how many hours of help do you receive each week?_____(hours).

50. Do you receive any of these services?

a. meals on wheels___yes___no. If yes, how helpful are they?

___very helpful_____helpful____helped very little.

b. transportation___yes___no. If yes, how helpful is this service?

____very helpful____helpful___helped very little.

c. EPIC (Elderly Prescription Insurance Coverage)___yes___no. If yes, how helpful is this?

____very helpful___helpful____helped very little.

d. other services? Explain_____. How helpful is this?

_____very helpful___helpful____helped very little.

51. Did receiving the above help influence your decision to apply for Medicaid in any way? If so, please explain.

52. Since you received Medicaid have there been any differences in your care or services? Please describe.

53. Has having Medicaid changed your use of medical services in any way? Please explain.

54. Do you use the same physician you used before you obtained Medicaid?

55. How many times per year do you see your primary care physican?_____

56. What is your medical diagnosis?

57. During the application process were you hospitalized?___yes___no. For how long, and for what reason?

58. What words of advice do you have for other older women who are considering applying for Medicaid?

59. What else would you like to tell me about your experience applying for Medicaid?

This concludes our interview. Thank you for your time. I would like to remind you that this interview is confidential and the information you gave me will be used for research purposes only.

Appendix 2

Outreach Materials

LENOX HILL
NEIGHBORHOOD
ASSOCIATION, INC.
331 EAST 70th ST., NEW YORK, N.Y. 10021 • (212) 744-5022

MRS. FELIX G. ROHATYN
Chairman

GUY G. RUTHERFURD, JR.
President

NANCY WACKSTEIN
Executive Director

July 2, 1992

Mr. Vincent Tancredi
Director of Eligibility
Information Services
Medical Assistance Program
11 Beach Street, Room 719
New York, N.Y. 10013

Dear Mr. Tancredi:

I am writing to you at the suggestion of Ms. Judy Mendell, Deputy Director of Training. At the last Manhattan Medicaid Advisory Council meeting I spoke with Ms. Mendell about my forthcoming research project. I am a doctoral student at the Hunter College School of Social Work, where I am doing research for my dissertation. The title of my dissertation is "Facilitating Access to Medicaid for Older Women." My research will focus in part on questionnaires administered to social workers and other advocates for the elderly. The goal of my study is to identify both the facilitators as well as the obstacles to Medicaid coverage for older women.

I would like to be invited to the next Citywide meeting so that I can tell the council about my project and hopefully distribute questionnaires for completion. Upon analysis of my findings I will develop training, practice and policy recommendations.

Please contact me at your earliest convenience. Thank you in advance for your assistance.

Sincerely,

Rebecca Mushkin

Rebecca Mushkin, ACSW
Director, Project SCOPE

RM/mac

JASA
JEWISH ASSOCIATION FOR SERVICES FOR THE AGED / 40 WEST 68th STREET / NEW YORK, N.Y. 10023 / 212-724-3200
An agency of UJA Federation

OCT 26 1992

October 14, 1992

Rebecca Mushkin, Director of Project SCOPE
Lenox Hill Neighborhood Association
331 West 71st Street
New York, NY 10021

Dear Rebecca,

This note is to thank you for presenting your dissertation research at our staff meeting last week. Your discussion of entitlements and community resources was informative, particularly for our interns. I hope our completed questionnaires prove helpful!

Sincerely,

Laura

Laura S. Kramer

LK:cm

THE ASSOCIATION OF THE BAR
OF THE CITY OF NEW YORK
42 WEST 44TH STREET
NEW YORK, N.Y. 10036-6690

COMMITTEE ON LEGAL PROBLEMS OF THE AGING

NANCY N. DUBLER
CHAIR
111 EAST 210TH STREET
BRONX, NY 10467
(212) 920-6226
FAX # (212) 798-6379

MORTON L. PRICE
SECRETARY
SUITE 3655
1185 AVENUE OF THE AMERICAS
NEW YORK, N.Y. 10036
(212) 575-8150
FAX # (212) 768-1305

TUESDAY
November 10, 1992
6:00 P.M.

AGENDA

I. Rebecca Mushkin--conducting research for a dissertation

II. Subcommittee Reports

A. Proposed Article 81 MHL
B. Patient Self-Determination/Advance Directives
C. Legal Problems of Financially Impoverished and Minority Elderly
D. Conservatorship Monitoring
E. Insurance
F. Elder Abuse

III. Committee Structure for 1992-93 -- Continued

IV. Legislation Liaison

V. Other Business

51\A.105/4

The Elder Law Exchange™
October/November 1992

Lamson & Petroff
Attorneys at Law
330 Madison Avenue
New York, NY 10017
Tel. (212) 297-3318

Message from the Editors

In an innovative move affecting long-term care for the elderly, New York State will encourage middle-income residents to buy State-approved nursing home insurance in a program that will exempt them from onerous Medicaid limits on personal resources. Those who buy the insurance, which also covers care at home, will no longer be forced to impoverish themselves to qualify for Medicaid.

State agencies hope the program will help slow the steep growth in New York's $6-billion-a-year Medicaid budget for long-term care. The program, characterized as a public/private partnership, was initiated through a planning grant from the Robert Wood Johnson Foundation. Its development has been under the direction of Mildred Shapiro, Associate Commissioner of the Division of Medical Assistance of the Department of Social Services. Her excellent article in this issue serves as an introduction to the program.

An Alternative Plan for Financing Long-Term Care

by Mildred B. Shapiro

If your mother is 65 this year the statistical probability is that she will live until the age of 84. For some, the life of an octogenarian is a full and active one, while for others, life becomes filled with concerns of failing health and dependency. In the case of those who are physically and emotionally dependent, the strain is on both the individual and the caregiver. Compounding the problem is the ever-increasing cost of long-term care to both family and to society.

Because Medicare, more often than not, does not cover long-term care and because long-term-care insurance has thus far played but a minor role in mitigating costs, Medicaid has become the primary insurer by default. But in order to become eligible for Medicaid, an individual who is not already on Supplemental Security Income (SSI), and thus automatically eligible for Medicaid, has two basic choices - impoverishment or divestiture of assets.

With the average cost of nursing-home care in New York State at approximately $62,000 for a private patient in 1991, the average stay of 26 months would cost about $132,600. Such a sum, either would not be readily available to most New Yorkers, or, if available, parted with reluctantly. Faced with the need for nursing-home care, a single middle-class person would have to either spend down all resources to $3,050 (the impoverishment level) before becoming Medicaid eligible or engage in what is euphemistically called "medicaid estate planning." Such financial planning often consists of either transferring assets as gifts or creating irrevocable trusts, the assets of which are considered "not available" to the donor and, by extension, to the Medicaid program. The growth of long-term-care costs in the Medicaid program, currently estimated at $6 billion in New York State, is due, at least in part, to greater utilization by middle-class New Yorkers. In an effort to promote the purchase of long-term-care insurance and to stem the astronomical rise in Medicaid costs, New York State has developed a public/private partnership.

Under this program individuals will be encouraged to purchase a State-approved, private long-term-care insurance policy from a participating insurance carrier. When the benefits (3 years of nursing-home care or 6 years of home care or a combination of the two) are exhausted, the individual will be eligible for Medicaid. Income contribution will be required but all the assets will be protected. The purpose of the partnership (private insurance coupled with public Medicaid) is a more

Continued on page 2

Mildred B. Shapiro is Associate Commissioner, Division of Medical Assistance, New York State Department of Social Services and Adjunct Professor, Health Studies Center, Union College. She was Associate Director of the State Health Planning Commission.

In this issue:

Message from the Editors
The RWJ Long-Term-Care Insurance Project: An Alternative Plan for Financing Long-Term Care
The Medicaid Home-Care Budget Cuts
SSA Allows In-Kind Support to be Considered a Loan
Legal Brief: Living Wills and Health-Care Proxies
About the Editors

Continued from page 3

family member or close friend - to decide about treatment if you lose the ability to decide for yourself. You can do this by using a health-care proxy in which you appoint your health-care agent to make sure that health-care professionals follow your wishes. Your agent can also decide how your wishes apply as your medical condition changes. Hospitals, nursing homes, doctors and other health-care providers must follow your agent's decisions as if they were your own. You can give the person you select as your health-care agent as little or as much authority as you want. You can allow your agent to decide about all health care or only certain treatments. You may also give your agent instructions that he/she must follow.

What is the difference between a living will and a health-care proxy? A living will is a written statement of your own wishes regarding medical treatment. The statement is to be followed if you are unable to provide instructions at the time medical decisions need to be made. The health-care proxy is significantly different from the living will. The proxy empowers a person to make health-care decisions on your behalf if you cannot do so yourself. The living will, on the other hand, has no such provision but enables you to express your own choices regarding medical treatment. It makes sense to utilize both a living will and a health-care proxy.

Can the health-care agent be legally or financially liable for decisions made on your behalf? No. Your agent will not be liable for treatment decisions made in good faith for you. Your agent cannot be held liable for costs of your care just because he/she is your agent.

Do I have to write an advance directive ? No. Signing a living will or health-care proxy is voluntary. No one can require you to complete either directive.

How do I make an advance directive? The advice of an attorney is helpful to ensure that your document accurately reflects your wishes and is legally effective. Consideration should be given if you plan to spend time in another state where the advance directive law may differ from that of New York.

Bulletin Board

Rebecca Mushkin, CSW, director of Project SCOPE of the Lenox Neighborhood Association is in the process of doing research for her doctoral dissertation which focuses on the factors influencing Medicaid access for older women. Eldercare attorneys, social workers and other advocates are needed to complete a questionnaire identifying the barriers and facilitators to Medicaid access. Those interested are asked to contact Ms. Mushkin at 212-744-5022, Ext. 209.

About the Editors

Lamson & Petroff, attorneys at law, provide a broad range of legal services, concentrating in the rights of elderly and disabled, estate planning, trusts, probate and matrimonial practice. Carole C. Lamson is a member of the National Academy of Elder Law Attorneys. She serves on the New York State Bar Association's Trust and Estate Section and Elder Law Section where she is active on both the Committee on Law of the Elderly and the Committee on Estates, Health and Personal Planning. Martin Petroff, formerly legal counsel for health affairs at the New York City Department for the Aging, is a member of the executive board of the New York State Bar Association's Law Section. He is also a member of the Committee on Legal Problems of the Aging of The Association of the Bar of the City of New York.

LAMSON & PETROFF
ATTORNEYS AT LAW
330 MADISON AVENUE
NEW YORK, NY 10017

Address Correction Requested
Return Postage Guaranteed

BULK RATE
U.S. POSTAGE
PAID
LIC, NY 11101
PERMIT NO. 198

Appendix 3

Medicaid Related Materials

GUIDE
to
DOCUMENTATION
for the
MEDICAID
APPLICATION

THE CITY OF NEW YORK
HUMAN RESOURCES ADMINISTRATION

STANLEY BREZENOFF
Administrator

DEPARTMENT OF SOCIAL SERVICES
BUREAU OF MEDICAL ASSISTANCE

HARRIET DRONSKA
Deputy Administrator

IN ORDER TO ESTABLISH YOUR ELIGIBILITY FOR MEDICAL ASSISTANCE YOU MUST COMPLETE THE ATTACHED APPLICATION FOR MEDICAL ASSISTANCE PRIOR TO YOUR APPOINTMENT

In order to establish that you are eligible for Medicaid, we must determine that you meet Federal and State financial and situational criteria. To do this, we require documentation for each statement you make on your Application, Reapplication, or Recertification form. This guide suggests possible items you may use. Because each person's situation is different, you may need to bring additional documents with you, or you may be asked to provide additional documents.

(A) FAMILY AND RELATIVE DATA. You must verify *WHO YOU ARE* and *WHERE YOU LIVE.* In addition, for you, and each member of your household you must prove *AGE, CITIZENSHIP OR ALIEN STATUS* and *FAMILY RELATIONSHIP* (wife, husband, children under 21).

1. IDENTIFICATION. To verify identity usually one of the documents listed below is sufficient. You may bring:

- •Birth Certificate
- •Hospital Certificate of Birth
- •Certificate of Birth from NYC Bureau of Vital Statistics
- •Marriage Certificate with Date of Birth
- •Immigration or Naturalization Papers
- •Passport
- •Current Driver's License
- •Prior Public Assistance and Medicaid Card
- •Medicare Card

If you have none of the above, bring two of the documents listed below to establish your identity.

- •Baptismal Certificate
- •Marriage Certificate without Birthdate
- •Naturalization Letter
- •Voter Registration Card
- •Military Discharge Papers
- •Professional License
- •High School/College Diploma
- •School Records
- •Permanent Residence Card
- •Letters of Guardianship
- •Methadone Program I.D.
- •Final Judgment of Divorce or Separation
- •Current Social Security Award Letters
- •Auto Registration
- •Life Insurance Policy
- •Deeds, Mortgages or other records of Home Ownership
- •Social Security Card/Railroad Retirement Card
- •Hospital Clinic Card

2. RESIDENCE. To verify your residence, usually one of the documents listed below is sufficient. You may bring:

- •NYCHA rent book
- •Rent receipt from landlord on his stationery
- •Recent utility bill in your name at the listed address
- •Hotel rent receipt
- •NYC real estate tax bill
- •Copy of current lease

3. CITIZENSHIP AND LEGAL ALIEN STATUS. To verify citizenship for each person born in the United States, bring one of the following:

- • Birth Certificate
- •Hospital Certificate of Birth
- •Certificate of Birth from NYC Bureau of Vital Statistics
- •Citizenship Papers
- •Baptismal Certificate
- •U.S. Passport
- •Military Discharge Paper (Form DD-214)

To verify Naturalized and Legal Alien Status for each person NOT born in the United States, bring one of the following:

- •Certificate of Citizenship
- •Certificate of Naturalization
- U.S. Passport
- •Military Discharge Papers
- •INS Form I-179/I-197 (resident I.D.)
- •Selective Service Registration Certificate

Evidence of Lawful Admission for Permanent Residence (INS Form I-151 (Alien Registration Receipt Card) or a Resident Permit

Evidence of Permanent Residence
INS Form I-94 (arrival-departure record) which is endorsed as "Refugee Conditional Entry" or is endorsed to show you have been given permission to remain in the U.S. for an indefinite period

NOTE

Other verification (not mentioned here) obtained from the Immigration and Naturalization Service is also acceptable.

4. **SOCIAL SECURITY.** A social security number is needed for all household members, including minor children, listed on the application. Please bring a Social Security Card for each person.

5. If any of the following situations – **DISABILITY, BLINDNESS, PREGNANCY, ABSENT PARENT** – apply to your family you must verify as follows:

a) If you are DISABLED and are receiving Social Security Disability Benefits, bring your Social Security Disability Award Letter or a signed letter from your doctor stating type of illness or disability and expected date of return to employment.
b) If you are BLIND, bring your Certificate of Blindness from New York State Commission for the Visually Handicapped.
c) To verify PREGNANCY bring signed doctor's statement or letter from clinic confirming pregnancy and expected delivery date.
d) ABSENT PARENT(S): If a Parent or Parents of children under 21 are absent from the household due to desertion, death, or other reasons, you must document as follows:
- If deceased: Death Certificate
- If in the military: Allotment papers or copies of checks
- If institutionalized: Date of entry into Institution, type of institution, etc.
- If desertion: Last known or current address of absent parent
- If supporting family: Weekly contribution or Court Order for Support/Docket No.

(B) LIVING ARRANGEMENTS. To verify your current HOUSING INFORMATION bring to your appointment the documents related to your situation

1. If you pay rent bring one of the following: Current rent receipt, cancelled rent check, or letter from your landlord or realty agent verifying name and address of landlord or realty agency and amount of rent
Copy of current lease

2. If someone helps you pay your rent bring Current statement from the person who helps you stating how much of the rent he/she pays, and to whom (to you or directly to the landlord or realty agency)

3. If you live in someone else's home, bring a written statement from that person. The statement should show
- Total rent
- Total number of persons in the household
- Amount paid by you
- If you receive free room and board
- Evidence of primary tenant's residence, e.g., a bill addressed to primary tenant

4. If you own your own home, bring: All your yearly bills pertaining to the home (tax bills or receipts, insurance, heating and utility bills, mortgages, bank statements, deeds, etc.).
If there are tenants in your home, bring any one of the following:
Current tenant's lease or statement from each tenant stating how much rent he/she pays, or recent copy of each tenant's rent receipt.

5. It will also be necessary for you to estimate your average monthly expenses for other living costs, such as food, clothing, telephone, medical expenses, etc.

(C) EMPLOYMENT Full or part-time employment must be verified for each member of the household who is applying for assistance. In addition, if any applicants in the household are unemployed children under 21, or spouses, employment must be verified for the responsible parent(s) or spouse, even if they are not applying for assistance.

1. If you are employed, bring with you one of the following for each job you hold:
- If you are paid every week, bring your last eight (8) pay stubs
- If you are paid every two weeks or twice a month, bring your last four (4) pay stubs
- If you cannot obtain the number of current pay stubs required, bring a statement from your employer, on business stationery, dated and signed with title and address, showing:
  the date you started to work, and your gross pay, and Federal, State and City taxes, FICA, and health insurance deducted, for the last eight (8) weeks or from the date of your employment if less than eight (8) weeks.
- If employed part-time number of hours worked per week.

2. Self-Employment: If you are self-employed: Bring your last Federal Income Tax return with Schedule C

3. Irregular Employment. If your employment is irregular: Bring your last Federal Income Tax and all W-2's.

4 Work-Related Expenses. If any of the following expenses apply to your current employment, bring signed statements, documents, bills, receipts, etc.:

- •Union dues
- •Cost of tools, materials and other special clothing required
- •Mandatory fees for licenses or permits fixed by law
- •Group insurance premiums
- •Child care expenses (signed statement should show the fee charged and hours of care)

(D) OTHER CURRENT INCOME.

1. If you receive any of the following, bring a copy of check or current statement from benefits program or award letter:

- •Workmen's Compensation
- •Veterans' Benefits
- •Social Security Benefits
- •Railroad Retirement Benefits
- •Pension from Employment
- •New York State Disability
- •G.I. Allotment
- •Union Benefits
- •Supplemental Security Income

2. If you receive any of the following, bring the appropriate document or statement, as indicated:

- •Interest from Bank Accounts – current bank books or bank statement
- •Dividends from stocks, bonds and life insurance – statement of dividends or copies of checks or statement from broker, life insurance policy.
- •Income from annuities – statement of annuity income or copies of checks
- •Income from trust fund – copy of trust fund document
- •Unemployment insurance benefits – unemployment insurance book or statement
- •Scholarships – statement from school of all financial aid with a breakdown of funds
- •Income from training program – statement from program
- •Court-ordered support payments – current check or copy of check, and court order
- •Support from relatives or friends – statement from relative(s) or friend(s) including full name(s), address(es), amounts and length of time
- •Income from roomers, boarders, mortgages – statement from roomers, boarders, including amount paid, copy of mortgage agreement
- •Food Stamps – food stamps ID Card
- •Other – list on application and bring in documentation of any other source of income you may have

(E) PAST MANAGEMENT.

1. If the information you have provided about income and expenses does not fully explain how you have managed to support yourself prior to this application, you may be asked to supply additional information or documents. Individual situations differ, but the following are suggestions for documents which might apply:

- •Tax statements for the past two (2) years
- •Letter from previous employer(s) giving dates of employment, annual salary, and reason for termination
- •Letters from persons who have contributed to your financial support, giving their name, address, telephone number, amounts, and dates
- •Documentation of expired benefits or rejected claims for benefits - Unemployment Insurance Benefits, Disability, Social Security, Workmen's Compensation, etc.
- •Cancelled bank books or statement of bank loans

2. If between the ages of 21-64 and not employed, bring proof of registration with New York State Employment Service.

3. If you are unable to work, bring a medical statement to verify this; the doctor's statement should indicate how long this is expected to last.

(F) RESOURCES. If you have RESOURCES and/or PROPERTY you must bring proof to show what you have. If you have any of the following, bring the appropriate documents as indicated:

- •Savings and Checking Accounts – savings books indicating activity for last 12 months, checking account statement for the last three months
- •Stocks and Bonds – certificates
- •Credit Union – copy of record of deposits
- •Real Property – deeds, mortgages, tax statements
- •Trust Fund – copy of the Trust Fund Document
- •Life Insurance and Annuities – life insurance and annuity policies
- •Pending Law Suit – any legal papers, name and address of lawyer
- •Union Benefits (including Life and/or Health Insurance policies
- •Health Insurance and Medicare - Medicare ID Card, health insurance policies, premium payment receipts
- •Other - list on application and bring in documentation of any other resources you may have

NOTE: IF YOU PREVIOUSLY HAD RESOURCES OR PROPERTY, YOU MAY BE ASKED TO VERIFY THEIR TERMINATION. BRING CANCELLED BANK BOOKS, ETC., OR LETTERS OF TERMINATION FROM BANKS, INSURANCE COMPANIES, ETC.

IF YOU HAVE TRANSFERRED OR SOLD ANY RESOURCES OR PROPERTY IN THE PAST 12 MONTHS, YOU MUST BRING IN DOCUMENTATION OF TRANSACTIONS.

W296C

Revised 891

Prepared by: HRA OFFICE OF PUBLIC AFFAIRS
Sam Elber, *Deputy Administrator*

Bibliography

Aday, L., Andersen, R., & Fleming, G. (1980). **Health Care in the United States: Equitable for whom? Beverly Hills, CA: Sage.**

Aday, L. & Andersen, R. M. (1981). Equality of access to medical care: A conceptual and empirical overview. **Medical Care, 19, December (supplement).**

Aday, L. A., Fleming, G. V. & Andersen, R. M. (1984). **Access to medical care in the US: Who has it, who doesn't. Chicago: Pluribus Press.**

Alexander, R. S. & Podair, S. (1969). Educating New York City residents to benefits of Medicaid. **Public Health Report, 34 (9), 767-771.**

Andersen, R. & Newman, J. (1973). Societal and individual determinants of medical care utilization in the U.S. **Milbank Memorial Fund Quarterly, 51: 95-124.**

Arendell, T. J. (1984). **Women at risk: The economic effects of divorce and their gender base. Paper presented at the annual meeting of the American Public Health Association.**

Arendell, T. & Estes, C. L. (1987). Unsettled future: Older women, economics and health. **Feminist Studies, 7 (1), 3-25.**

Auerbach, M., Gordon, D. W., Ullman, A. & Wiesel, M. J. (1977). Health care in a selected urban elderly population. **The Gerontologist, 17: 341-346.**

Bengtson, V. L., Cutler, N. E., Mangen, D. J. & Marshall, V. W. (1985). Generations, cohorts, and relations between age groups. In R. H. Binstock & E. Shanas (Eds.), **Handbook of Aging and the Social Science (2nd ed.). New York: Van Nostrand Reinhold.**

Block, M.R. (1982). Professional women: Work pattern as a correlate of retirement satisfaction. In M. Szinovacz (Ed.), **Women's Retirement, (pp. 183-194). Beverly Hill: Sage.**

Bovbjerg, R. R. & Holahan, J. (1982). **Medicaid in the Reagan era: Federal policy and state choices, Washington, DC: Urban Institute.**

Branch, L., Friedman, D., Cohen, M., Smith, N. & Socholitzky, E. (1988). Impoverishing the elderly: A case study of the financial risk of spend-down among the Massachusetts elderly

people. The Gerontologist, 28, 648-652.

Brown, E. R. (1984). Medicare and Medicaid: The process, value and limits of health care reforms. In M. Minkler & C. L. Estes (Eds.), Readings in the political economy of aging (pp. 117-143). Farmingdale, NY: Baywood.

Burney, I. L., Schieber, G. J., Blaxall, M. O. & Gabel, J. R. (1979). Medicare & Medicaid physician payment incentives. Health Care Financing Review, 1, Summer.

Burton, J. L. (1980). Elder women suffer frequently and severely during retirement, Generations, 4, 12, 36.

Butler, L. H. & Newacheck (1980). Health and social factors relevant to long term care policy, Institute of health policy studies, University of CA, San Francisco.

Butler, R. N. (1979). US National Institute on Aging. The older Woman: Continuities and Discontinuities, Washington, D.C.: US Government Printing Office.

Cafferata, G. L. (1987). Marital status, living arrangements and the use of health services by elderly persons. Journal of Gerontology, 42, 613-618.

Cantor, M. & Mayer, M. (1976). Health care and the inner city elderly. The Gerontologist, 16: 17-26.

Cantor, M. (1983). Social care for the aged in the United States: Issues and challenges. Reprint. New York: The Haworth Press, Inc.

Chang, D. & Holohan, J. (1990). Medicaid spending in the 1980's: The access-cost containment trade-off revisited. Washington, DC: Urban Institute.

Chenoweth, L. C. & Maret, E. (1980). The career patterns of mature American women. Sociology of Work & Occupation, 7, 222-251.

Commonwealth Fund Commission on Elderly People living alone (1987). Old, alone and poor: A plan for reducing poverty among elderly people living alone. New York Commonwealth Fund.

Cronin, M. (1987). Director of Legislative Analysis, New York City Medicaid Program, Interview with C. Muller.

Crystal, S. (1990). Health economics, old age politics, and the catastrophic Medicare debate. Journal of Gerontological Social Work, 15 (3/4), 21-31.

Crystal, S. & Shea, D. (1989). The economic resources of the elderly: A comprehensive income approach. Survey of income and program participation working paper No. 89-14. Washington, DC: Bureau of the Census.

Darling, H. (1986). The role of the federal government in assuring access to health care. Inquiry, 23, 286.

Davis. K., Gold, M. & Makuc, D. (1981). Access to health care for the poor: Does the gap remain? Annual Review of Public Health, 2, 159-182.

Dressel, P. L. (1988). Gender, race, and class: Beyond the feminization of poverty in later life. The Gerontologist, 28, (2), 117-180.

Dutton, D. (1986). Social class, health and illness. In L. Aiken & D. Mechanic (Eds.), Applications of Social Science to clinical medicine & health policy (pp. 31-62). New Brunswick, NJ: Rutgers University Press.

Edelstein, S. C. (1989). Long term care legislation: Where are we, how did we get here, and where do we go from here? Journal of Home Health Care, 8, 30-33.

Ehrenreich, B. & Piven, F. F. (1984). The feminization of poverty. Dissent, 2, 162-170.

Estes, C. L. (1989). Aging, health, and social policy: Crisis and crossroads. Journal of Aging & Social Policy, 1 (1/2), 17-32.

Estes, C. L. & Binney, E. A. (1988). Toward a transformation of health and aging policy. International Journal of Health Services, 18 (1): 69-82.

Estes, C. L., Gerard, L. E. & Clarke, A. (1984). Women and the economics of aging. In M. Minkler & C. L. Estes (Eds.), Readings in the political economy of aging (pp. 209-224). Farmingdale, NY: Baywood.

Farley, P. (1985). Selectivity in the demand for health insurance and health care. Hyattsville, MD: US Center for Health Services Research.

Farrell, K. A. (1989). State Expenditure Report. Washington, DC: National Association of State Budget Officers.

Feder, J. & Holahan, J. R. (Eds.) (1986). Medicaid Program Evaluation: A Synthesis of Interim Findings, MPE 9.1. Health care Financing Administration. Baltimore, MD.

Feder, J., Moon, M. & Scanlon, W. (1987). Medicare reform: Nibbling at catastrophic costs. **Health Affairs, 6: (5-19).**

Fox, P. D. (1972). Access to medical care for the poor: The federal perspective. **Medical care, 10 (May/June): 272-277.**

Freeman, H. E., Blendon, R. J., Aiken et al. (1987). Americans report on their access to health care. **Health Affairs, 6, 6-18.**

Fuller, M. M. & Martin, C. A. (1980). **The older woman, Springfield, Ill: C. C. Thomas.**

Gershick, L. B. & Williamson, J. B. (1982). The politics of measuring poverty among the elderly. **Policy Studies Journal, 10 (3): 483-499.**

Gifis, S. H. (1991). Law Dictionary (3rd ed.).Newark:Barron's.

Gornick, M., Greenberg, J., Eggers, P. & Dobson, A. (1985). **Twenty years of Medicare and Medicaid: Covered populations, use of benefits, and program expenditures, Health Care Financing Review. 1985 Supplement.**

Grau, L. (1987). Illness engendered poverty among the elderly. **Women & Health, 12 (3/4), 103-118.**

Harrington, C., Estes, C. L., Lee, P. R. & Newcomer, R. J. (1986). Effects of state Medicaid policies on the aged. **The Gerontologist, 26 (4), 437-443.**

Harris, L. (1988). **Testimony (March 29) in The Need for Long Term Care: A survey of Public Opinion. Hearings before the subcommittee on Health and Long Term Care, House Select Committee on Aging, Washington, DC.**

Herriot, R. A. & Kasprzyk, D. (1986). **Some aspects of the survey of income and program participation working paper No. 86-01. Washington, DC: Bureau of Census.**

Hobbs, D. (1987). Strategy for needs assessment. In D. E. Johnson, L. R. Meiller, L. C. Miller & G. F. Summers (Eds.), **Needs assessments: theory and methods. Ames, IA: Iowa University Press.**

Hochbaum, M. & Galkin, F. (1987). Medicaid patients need not apply. **Social Policy, 17 (4): 40-42.**

Holahan, J. & Cohen, J. W. (1986). **Medicaid: The trade-off between cost containment and access. Washington, DC: Urban Institute Press.**

Hurd, M. (1989). Economic status of the elderly. **Science, 244: 659-665.**

ICF, Incorporated. (1986). **Medicaid's Role in Financing the health care of Older Women. Prepared for the American Association of Retired Persons, Washington, DC.**

Joe, T. C., Meltzer, J. & Yu, P. (1985). Arbitrary access to care: The case for reforming Medicaid. **Health Affairs, 4, 59-74.**

Kane, R. L. & Kane, R. A. (1978). Care of the aged: Old problems in need of new solutions. **Science, 200, 913-919.**

Kasper, J.D. (1986). Health status & utilization: Differnces by Medicaid coverage and income. **Health Care Financing Review, 7 (4): 1-17.**

Katz, S., Ford, A. B., Moskowitz, R. W., Jackson, B. A. & Jaffee, M. W. (1963). Studies of illness in the aged. The index of ADL. **Journal of the American Medical Association, 185: 94-101.**

Kniesberg, Louis (1963). The relationship between socioeconomic rank and behavior. **Social problems, 10 (Spring): 349-**

Kovar, M. G. (1986). Expenditures for the medical care of the elderly living in the community 1980. **The Milbank Quarterly, 64, 100-132.**

Kutza, E. (1981). **The Benefits of Old Age. Chicago: The University of Chicago Press.**

Lehrman, P. (1980). Poverty statistics serve as nagging reminder, **Generations, 4 (1), 17-18, 76.**

Letsch, S., Levit, K. & Waldo, D. (1988). National Health Expenditures, 1987. **Health Care Financing Review, 10 (2): 109-122.**

Lewis, M. I. & Butler, R. N. (1984). Why is women's lib ignoring old women? In M. Minkler & C. L. Estes (Eds.), **Readings in the political economy of aging (pp. 109-208). Farmingdale, NY: Baywood.**

Liu, K., Doty, P. & Manton, K. (1990). Medicaid spend-down in nursing homes. **The Gerontologist, 30 (1), 7-15.**

Liu, K. & Manton, K. G. (1989). Effect of nursing home use on

Medicaid eligibility. **The Gerontologist, 29, 59-66.**

Loebs, S. F. (1970). Medicaid-A survey of indicators and issues, in **The Medical Experience, A. D. Spiegel (Ed.), Aspen Systems Corporation,** Germantown, MD.

Luft, H. (1978). **Poverty & Health: Economic causes and consequences of health problems. Cambridge, MA: Ballinger.**

Mangen, D. J. & Peterson, W. A. (1982). **Research instruments in social gerontology. Minneapolis: University of Minnesota Press.**

McMillan, A. (1983). A study of the "Crossover population" aged persons entitled to both Medicare and Medicaid. **Health Care Financing Review, 4, (4), 19-46.**

McMillan, A. & Gornick, M. (1984). The dually entitled elderly Medicare and Medicaid population living in the community. **Health Care Financing Review, 6 (2): 73-85.**

Medicaid/Medicare Management Institute. **Data on the Medicaid Program: Eligibility, Services, Expenditures, 1979, Health Care Financing Administration, Baltimore, MD.**

Meyer, M. H. & Quandagno, J. (1990). The dilemma of poverty based long term care. In S. Stahl (Ed.) **The legacy of longevity. Beverly Hills, CA: Sage.**

Minkler, M. & Stone, R. (1985). The feminizationof poverty and older women. **The Gerontologist, 25, (4), 351-357.**

Monk, A. (1990). Health care for the aged: The pursuit of equity and comprehensiveness. **Journal of Gerontological Social Work, 15 (3/4), 1-20.**

Morrison, B. J. (1983). Physical health and the minority aged. In R. L. McNeely & J. N. Colen (Eds.), **Aging in minority groups, Beverly Hills: Sage.**

Muller, C. (1983). Income supports for older women. **Social Policy, 14: 23-31.**

Muller, C. (1988). Medicaid: The lower tier of health care for women. **Women & Health, 14 (2), 81-103.**

Mushkin, R. (1992). Program evaluation, unpublished assessment of Project SCOPE.

Nagli, S. Z. (1976). An epidemiology of disability among

adults in the US. Milbank Memorial Fund Quarterly, 54: 439-468.

National Women's Law Center, (1983). Inequity of Sacrifice: The Impact of the Reagan Budget on Women, Washington, DC, March 16.

Neuschler, E. (1988). Medicaid eligibility for frail elders. Baltimore: The Commonwealth Fund.

Oktay, J. S. & Palley, H. A. (1991). The Medicaid personal care services program: Implication for social work practice. Health and Social Work, 16 (2), 110-117.

Older Women's League (1986). Report on the status of midlife and women. Washington, DC: Older women's league.

Olendzki, M. C., Grann, R. P., & Goodrich, C. H. (1972). The impact of medicaid on private care for the urban poor. Medical Care, 10.

Olson, L. (1982). The political economy of aging. Columbia University Press, NY.

O'Rand, A. M. (1983). Loss of work role and subjective health assessment in later life among men and unmarried women. In A. C. Kerckhoff (Ed.) Research in the Sociology of Education and Socialization, 5, San Francisco: JAI Press.

Osberg, C. N. & Polich, C. L. (1988). Medicaid: Entering the third decade. Health Affairs, 7, 83-96.

Palley, H. A. & Oktay, J. S. (1983). The chronically limited elderly: The case for a national policy for inhome and community based services. New York: Haworth Press.

Palley, H. A. & Oktay, J. S. (1989). Issues in setting the agenda for a long-term care policy for the frail elderly. Home Health Care Services Quarterly, 10 (3/4), 15-43.

Paringer, L. (1985). Medicaid policy changes in long term care: A framework for impact assessment. In C. Harrington, R. J. Newcomer & C. L. Estes (Eds.), Long term care of the elderly (pp. 233-250). Beverly Hills, CA: Sage.

Petchers, M. & Milligan, S. E. (1988). Access to health care in a black urban elderly population. The Gerontologist, 28 (2), 213-217.

Quadagno, J., Meyer, M. H. & Turner, J. B. (1991). Falling into the Medicaid gap: The hidden long-term care dilemma. The Gerontologist, 31 (4), 521-526.

Rice, D. (1986). Living longer in the US: Social and economic implications. Journal of Medical Practice Management, 1 (3), 162-169.

Rice, D. & LaPlante, M. (1988). Chronic illness, disability and increased longevity. In S. Sullivan & M. E. Lewin (Eds.). The economics and ethics of long term care and disability (pp. 9-55). Washington, DC: American Enterprise Institute for Public Policy.

Rich, B. & Baum, M. M. (1984). The Aging: A guide to public policy. Pittsburgh, PA: University of Pittsburg Press.

Rivlin, A. M. & Wiener, J. A. (1988). Caring for the disabled elderly. The Brookings Institute: Washington, DC.

Roos, N. P., Shapiro, E. & Roos, L. L. (1984). Aging and the demand for health services: Which aged and whose demand? The Gerontologist, 24, 31-36.

Rubinstein, E. S. (1991). Emergency surgery for Medicaid. The City Journal, Spring, 46-56.

Rymer, M. (1984). Health care financing grants and contracts report. Short term evluation of Medicaid: Selected Issues. Health Care Financing Administration. Baltimore, MD.

Schultz, J. H. (1984). The Economics of Aging. Belmont, CA: Wadsworth Publishing.

Select Committee on Aging, House of Representatives, (1985). Twentieth anniversary of Medicare and Medicaid. Americans still at risk. Pub. No. 99-538, GPO Washington, DC: US Government Printing Office.

Sidel, R. (1986). Women and Children Last: The plight of poor women in affluent America. New York: Viking Penguin.

Smeeding, T. M. (1986). Non-money income and the elderly: The case of the 'tweeners. Journal of Policy Analysis and Management, 5: 707-724.

Social Security Bulletin, (Spring, 1993). 56 (1).

Soldo, B. & Manton, K. (1985). Health status and service needs of the oldest old: Current patterns and future trends. Milbank Memorial Fund Quarterly, 63, 286-319.

Sparer, E. (1981). Guardian Knots: The situation of Health care Advocacy for the poor today. Clearinghouse Review, 15, May.

Spence, D. A. (1989). Caring for the disabled elderly: An assessment of long term care financing legislation. Pride Institute Journal of Long Term Home Health Care, 8 (2), 36-41.

Stahl, S. M. & Gardner, G. (1976). A contradiction in the health care delivery system: Problems of access. Sociological Quarterly, 17, 121-129.

State Comptroller, State of New York (1989). Staff study on New York State's Medicaid program. New York: Division of Management audit.

Stevens, R. & Stevens R. (1974). Welfare Medicine in America: A case study of Medicaid. Free Press: New York.

Stone, R. & Minkler, M. (1984). The sociopolitical context of women's retirement. In M. Minkler & C. L. Estes (Eds.), Readings in the Political Economy of Aging (pp. 225-238). Famingdale, NY: Baywood.

Strain, L. A. (1991). Use of health services in later life: The influence of health beliefs. Journal of Gerontology, 46 (3), S143-150.

Strauss, A. & Corbin, J. (1990). Basics of Qualitative Research: Gounded theory, procedures and techniques. Newbury Park: Sage.

Study finds elderly women more susceptible to poverty. (1984, September 24). New York Times.

Sulvetta, M. B. & Swartz, K. (1986). The uninsured and uncompensated care: A chartbook. Washington, DC: National Health Policy Forum.

Tilly, J. & Brenner, D. (1987). Medicaid eligibility and its effect on the elderly. Washington DC: American Association of Retired Persons.

U. S. Bureau of the Census (1992). Statistical Abstract of the United States: 1992. Washington,D.C: Reference Press.

U. S. Congress, House Select Committee on aging (1985). America's elderly at risk (Committee Publication No. 99-508). Washington, DC: US Government Printing Office.

U. S. Senate Special Committee on Aging (1975). Women and Social Security: Adapting to a new era, Superintendent of Documents, U. S. Government Printing Office, Washington, DC.

U. S. Senate Special Committee on Aging (1983). Developments in Aging. Washington, DC: US Government Printing Office.

U. S. Senate Special Committee on Aging (1988). Developments in aging 1987 (3). **The long term challenge. Washington, DC: U.S. Government Printing Office.**

Villers Foundation. (1987). **On the other side of easy street. Washington, DC: Villers Foundation.**

Wan, T. (1982). Use of health service by the elderly in low income communities. **Milbank Memorial Fund Quarterly, 60, 82-107.**

Wan, T. H. & Odell, B. G. (1981). Factors affecting the use of social and health services among the elderly. **Ageing and society, 1, 95-115.**

Warlick, J. L. (1983). Aged Women in Poverty: A problem without a solution? **In Aging and Public Policy, W. P. Browne and L. Olson (Eds.) Westport, CT: Greenwood Press.**

Waxman, C. I. (1977). **The stigma of poverty: A critique of poverty theories and policies. New York: Peragom Press.**

Wilensky, H. (1975). **The welfare state and equality: Structural & Ideological roots of public expenditure. Berkley, CA: Univ. of CA Press.**

Wolf, J., Breslau, N., Ford, A., Ziegler, H. & Ward, A. (1983). Access of the black urban elderly to medical care. **Journal of the National Medical Association, 75, 41-46.**

Wolinsky, F. D. & Johnson, R. J. (1991). The use of health services by older adults. **Journal of Gerontology, 46 (6), S345-357.**

Women's studies program and policy center at George Washington University and the women's research and educational institute of the congresswomen's caucus (1981), **Older Women: The Economics of Aging, Washington, DC.**

Yarrow, J. H. (1991). **Client due process rights in community based long-term care: Executive summary (Research grant). Washington, DC: National Council on Aging, Inc.**

Zones, J. S., Estes, C. L. & Binney, E. A. (1987). Gender, public policy and the oldest old. **Ageing and Society, 7, 175-302.**