



**Geiger Gibson /
RCHN Community Health Foundation Research Collaborative
Policy Research Brief No. 6**

**Assessing the Effects of Medicaid Documentation
Requirements on Health Centers and Their Patients:
Results of a “Second Wave” Survey**

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October, 2008

About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after health center and human rights pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on health centers, their history and contributions, and the major policy issues that affect health centers and the communities and patients they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit operating foundation whose purpose is to support community health centers through strategic investment, advocacy, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on a 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved, medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Executive Summary

This report represents a “second wave” follow-up to a “first wave” study whose purpose was to measure the effects of the Deficit Reduction Act’s citizenship documentation requirements on health centers and their patients. The earlier study, conducted six months after implementation, found that the law had a widespread impact, including delayed applications, interrupted enrollment, disruptions in care, and at least anecdotal evidence of a growth in the number of uninsured patients as a result of the denial or loss of Medicaid coverage. This “second wave” survey underscores the existence of serious, ongoing problems more than a year after implementation. Specifically, the second wave survey finds that:

- Three-quarters of all health centers continue to experience significant problems with citizenship documentation barriers for one or more patient groups; among health centers experiencing problems, the situation appears to be worsening rather than lessening on key measures.
- Documentation requirements appear to have particularly affected several specific patient categories, including pregnant women, children, patients new to the service area, and newborns.
- About one-third of health centers report a longer and more difficult application and enrollment process.
- Nearly one-half of health centers continue to report that Medicaid application and enrollment disruptions and delays continue to affect their ability to arrange for specialty care and many affected centers report increased costs associated with helping patients with application and enrollment problems.
- Although regulatory changes issued in 2007 were intended to address the problem, a significant number of health centers continue to report enrollment delays affecting newborns.
- Despite the fact that the DRA did not modify the State Children’s Health Insurance Program (SCHIP) when administered as a separate program, fully one-third of health centers located in states with separate SCHIP programs, and 45 percent of respondents in states with combination programs (Medicaid expansions plus a separate SCHIP expansion), reported that citizenship documentation requirements are being applied to SCHIP applicants as well.

These findings suggest that changes implemented in the final rules have done little to ease burdens associated with the DRA’s citizenship documentation requirements, and that the law’s greatest impact is falling on low income children and pregnant women and the health care providers that serve them.

Introduction

This analysis serves as the second wave of a study whose purpose was to assess the effects of the Deficit Reduction Act's ("DRA") citizenship documentation requirements on health centers and their patients. Following a background and a brief discussion of our research methods, we present our findings and conclude with a discussion of the implications of the citizenship documentation requirements for the health of low income patients and communities, as well as the ability of health centers to practice in conformance with recognized standards of quality and access.

Background

In February 2006, President Bush signed into law the Deficit Reduction Act of 2005 ("DRA"),¹ which revised prior Medicaid policy to require nearly all applicants and recipients to furnish proof of U.S. citizenship and identity at the time of application or renewal. The citizenship documentation requirements became effective on July 1, 2006. Final regulations were published in 2007² following the release of interim final rules in 2006. The final rules expand the list of persons who are exempt from citizenship documentation requirements (predominantly elderly and disabled persons, as well as children in state custody). The rules also somewhat broaden the list of documents that applicants can use to prove citizenship and extend Medicaid benefits for up to one year for those newborns whose mothers were receiving Medicaid at the time of the child's birth, regardless of the mother's immigration status. In addition, the rules expand the list of documents that applicants can use to prove citizenship to include "early school records showing U.S. place of birth," The *Roll of Alaska Natives*, and certain religious records filed in the U.S. within three months of birth.

Since the law's enactment and implementation, the citizenship documentation requirements have been the subject of much debate, and numerous studies have assessed the fiscal and other effects of the requirements on states and Medicaid beneficiaries. Although the intent of the statute was to prevent persons who are not legal U.S. residents or citizens from receiving Medicaid, the evidence suggests that the law has had only a limited effect on non-citizens and that the thrust of its impact has been on low income citizens and the health care providers that serve them.³ A 2006 survey conducted by the Center on Budget

¹ Pub. L. 109-171 (109th Cong. 2d Sess.)

² "Medicaid Program; Citizenship Documentation Requirements" (CMS2257F) (72 FR 38662). Federal Register CFR Citation 42 CFR Parts 435, 436, 440, 441, 457, and 483

³ D.C. Ross, "New Medicaid Citizenship Documentation Requirement is Taking a Toll. States Report Enrollment is Down and Administrative Costs Are Up," Center on Budget and Policy Priorities, March 13, 2007; P. Shin, B. Finnegan, L. Hughes, and S. Rosenbaum, "The Medicaid Documentation Requirements: An Initial Assessment of Medicaid Documentation Requirements on Health Centers and Their Patients," GW School of Public Health and Health Services, May 2007; "As Tough Times Wane, States Act to Improve Medicaid Coverage and Policy: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2007 and 2008," Kaiser Commission on Medicaid and the Uninsured, October 2007.

and Policy Priorities (CBPP) found that almost one in twelve (eight percent) of U.S.-born adults with incomes below \$25,000 reported not having a U.S. passport or U.S. birth certificate “in their possession,” and further, that 10 percent did not possess a birth certificate or passport for one or more of their children. The report concluded that Medicaid coverage could be jeopardized for an estimated 1.2 million to 2.3 million citizens, including up to 1.6 million children.⁴

A GAO survey of state Medicaid offices conducted in March/April 2007 found that the citizenship documentation requirement not only failed to reap predicted financial benefits, but actually resulted in increased administrative burden and costs to many states, as well as delayed and denied coverage for eligible individuals nationwide. One state reported that over 18,000 likely eligible individuals were denied coverage because they were unable to provide the required documentation.⁵ An analysis by the Majority staff of the House of Representatives Committee on Oversight and Government Reform noted that six states spent more than \$8.3 million in federal funds to find eight undocumented immigrants erroneously utilizing Medicaid services.⁶ The same study found that for every \$100 spent by taxpayers to implement the requirement, the federal government saved only 14 cents. The Center on Budget and Policy Priorities reported that children were particularly affected, with eligible children losing coverage as a result of an application backlog and a more complex renewal process.⁷ Research by other groups has returned similar findings.⁸

Six months following implementation of the citizenship documentation requirements in mid-2006, GW researchers undertook a “first wave” national survey of health centers, in order to provide an early assessment of the impact of the citizenship documentation requirements on health centers and their patients. The nation’s community health centers represent a major source of primary health care for both Medicaid beneficiaries and low income uninsured individuals and families; for this reason, their experiences can be viewed as bellwethers of how major changes in Medicaid policy affect a low income population and the systems of care on which they depend. In 2007, the nation’s 1,067 federally

⁴ L. Ku, D.C. Ross, and M. Broaddus, “Survey Indicates Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens,” Center on Budget and Policy Priorities, February 17, 2006. <http://www.cbpp.org/1-26-06health.htm>; L. Ku, “Revised Medicaid Documentation Requirement Jeopardizes Coverage for 1 to 2 million Citizens” at <http://www.cbpp.org/7-13-06health2.htm>, accessed September 12, 2008.

⁵ “Medicaid: States Reported Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens,” U.S. Government Accountability Office, GAO/07-889, July 2007.

⁶ “Medicaid Citizenship Documentation Requirements Deny Coverage to Citizens and Cost Taxpayers Millions,” Committee on Oversight and Government Reform, Majority Staff, July 24, 2007.

⁷ Ibid, D.C. Ross, March 13, 2007.

⁸ Ibid, Kaiser Commission on Medicaid and the Uninsured, October 10, 2007; L. Ku, and D.C. Ross, “New Medicaid Requirement is Unnecessary and Could Impede Citizens’ Coverage,” Center on Budget and Policy Priorities, January 4, 2006; “Impact of the federal 2005 Deficit Reduction Act on Colorado Medicaid enrollment: Findings from the Outreach and Enrollment Worker Survey,” Colorado Health Institute, May 2007.

funded health centers furnished health care in over 6,200 service sites to more than 16 million persons, including 5.68 million Medicaid beneficiaries or 35 percent of all patients served. Community health centers also represent a central source of primary health care for a growing uninsured population, particularly as other sources of primary health care for the low income population continue to shrink. In 2007, 40 percent (6.2 million) of all patients seeking care at community health centers were uninsured.⁹ When the number of uninsured grew by 35 percent nationally between 1990 and 2007, the number of uninsured persons served at health centers grew by *172 percent*.¹⁰ In 2007, Medicaid accounted for 37 percent of health centers' operating funds, making Medicaid the single most important source of health center financing.¹¹

Health centers provide both comprehensive primary health care as well as services that assist patients to actually receive care such as transportation, translation, and assistance in completing Medicaid application forms and in securing necessary documents and supporting information. In recognition of community health centers' role in gaining access to coverage, federal law requires states to outstation eligibility workers to provide Medicaid application enrollment assistance at community health centers.¹² In 2007, all health center grantees offered enabling services at most or all service sites, at a cost of \$519 million.

This "first wave" health center survey¹³ documented the law's widespread effects on both patients and health center practice, with evidence of enrollment disruption and delay and serious disruptions in care, particularly specialty care. While some disruption was expected within the first few months following implementation, the study found that nine out of ten health centers were experiencing substantial application and enrollment problems more than six months after implementation of the law. Some health centers also reported a growth in the number of uninsured patients as a result of new enrollment barriers arising from the documentation requirements.

Study Methodology: Second Wave Survey

The sweep and complexity of the DRA citizenship documentation requirements, coupled with state inexperience in documenting citizenship (prior to the enactment of the DRA, only four states¹⁴ required citizenship documentation)

⁹ R.E. Hurley, L.E. Felland, and J.Lauer, "Community Health Centers Tackle Rising Demands and Expectations," Center for Study Health System Change, 2007.

¹⁰ GW Department of Health Policy analysis of 2007 UDS

¹¹ Ibid

¹² 42 U.S.C. §1396a(a)(55).

¹³ P. Shin, B. Finnegan, L. Hughes, and S. Rosenbaum, "The Medicaid Documentation Requirements: An Initial Assessment of Medicaid Documentation Requirements on Health Centers and Their Patients," GW Department of Health Policy, May 2007.

¹⁴ Georgia, Montana, New Hampshire, and New York.

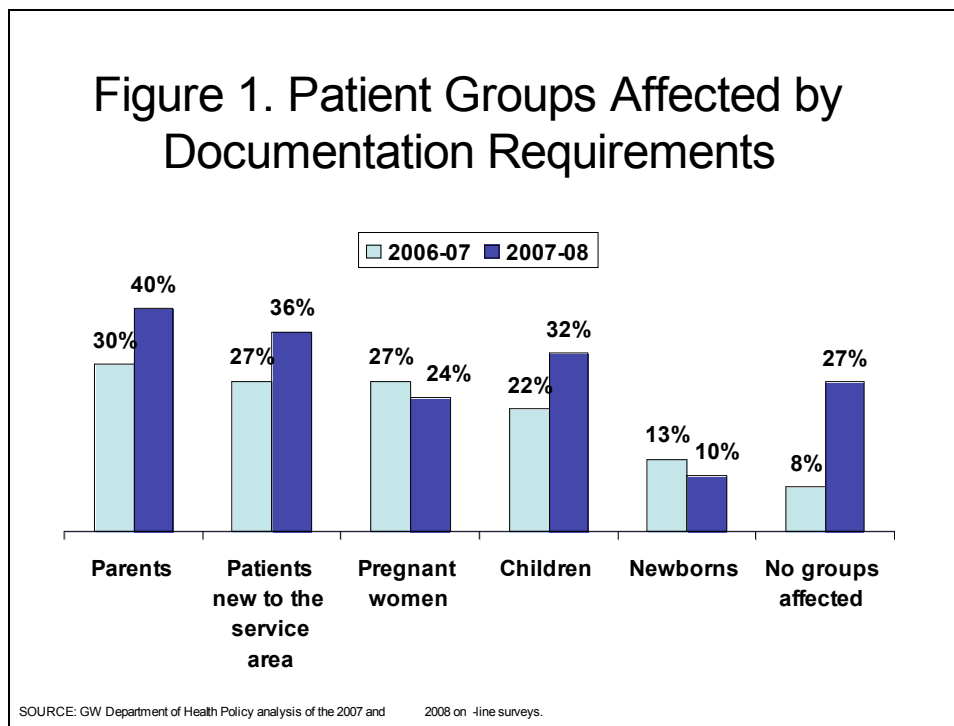
meant that states elected to implement the documentation requirements in stages.¹⁵ GW's first wave study was conducted six months after initial implementation of the citizenship documentation requirements. This second wave study re-examines the affects of the requirements some 15 to 18 months after implementation. Designed to assess the impact of the documentation requirements on health centers and their patients, this second wave study, like its predecessor, consisted of an online survey calculated to gauge health center experiences with citizenship documentation and was administered to all federally funded health centers. A total of 260 of 974 health centers nationwide (27 percent) responded to the survey. Responses came from health centers in 48 states and the District of Columbia. Respondent characteristics closely resemble health centers nationally.

Because the second wave survey was not targeted to the same cohort of health centers that participated in the previous study, any changes over time may not reflect actual trends. Instead, results from the previous study are included in the analysis to assess the extent to which early disruptions in access to coverage and care may (or may not) have stabilized after one year. A more detailed methodology covering each element of this study can be found in the Appendix to this Policy Brief. Wherever the same questions were asked in the 2006-07 study, estimates from both are included.

Findings

The most important finding to emerge from this second wave survey is the continuing widespread effects of the citizenship documentation requirements on health centers and their patients. Although the proportion of health centers experiencing no problems for specific patient groups increased from eight percent to 27 percent (**Figure 1**), nearly 75 percent of all respondents reported problems for one or more groups of patients. **Figure 1** shows that application and enrollment problems are affecting several key health center patient categories. Forty percent of health centers reported difficulties for parents, 36 percent reported problems for new patients, 24 percent reported problems affecting pregnant women, and 32 percent reported difficulties among children. Of perhaps greatest concern, a significant proportion of health centers – 10 percent – reported problems affecting newborns, a number which remains relatively unchanged from our earlier report, despite the exemption of newborns in the final rule.

¹⁵ Ibid, Kaiser Commission on Medicaid and the Uninsured, October 2007.



For health centers reporting problems, the evidence suggests that problems associated with documentation requirements have intensified rather than eased over time. **Figure 2** indicates that more than one year following implementation of the DRA citizen documentation requirements, the application process continued to prove difficult for health center patients. The percentage of health centers reporting a longer enrollment process increased, rising to 46 percent in the second wave time period. Thirty percent of second wave respondents reported that the application process had grown longer, while 38 percent – compared to 28 percent during 2006-07 time period – reported documentation problems.

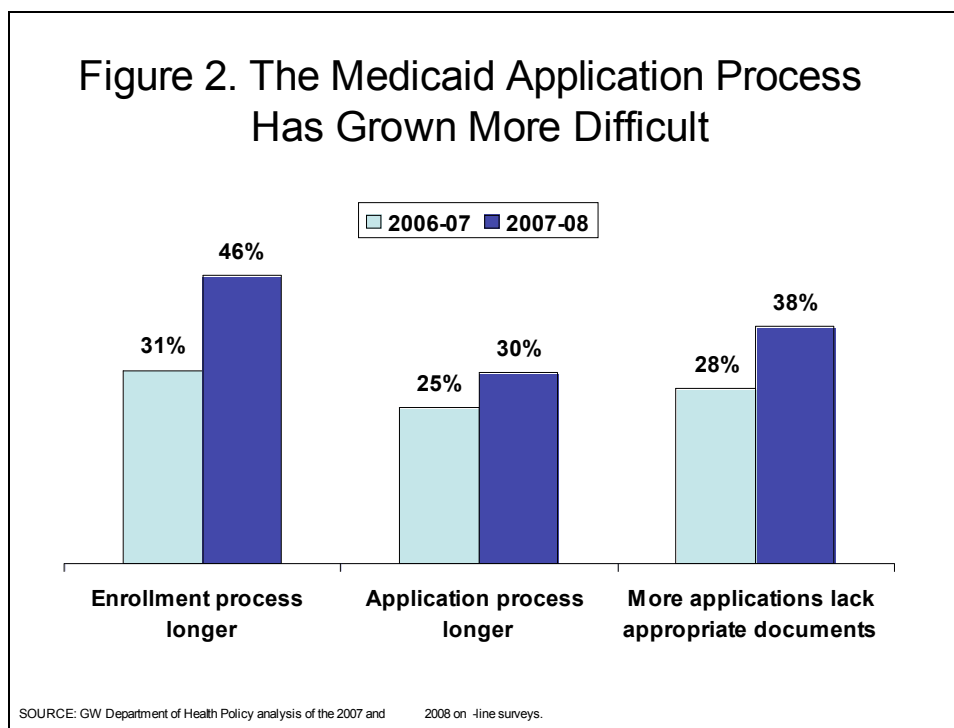
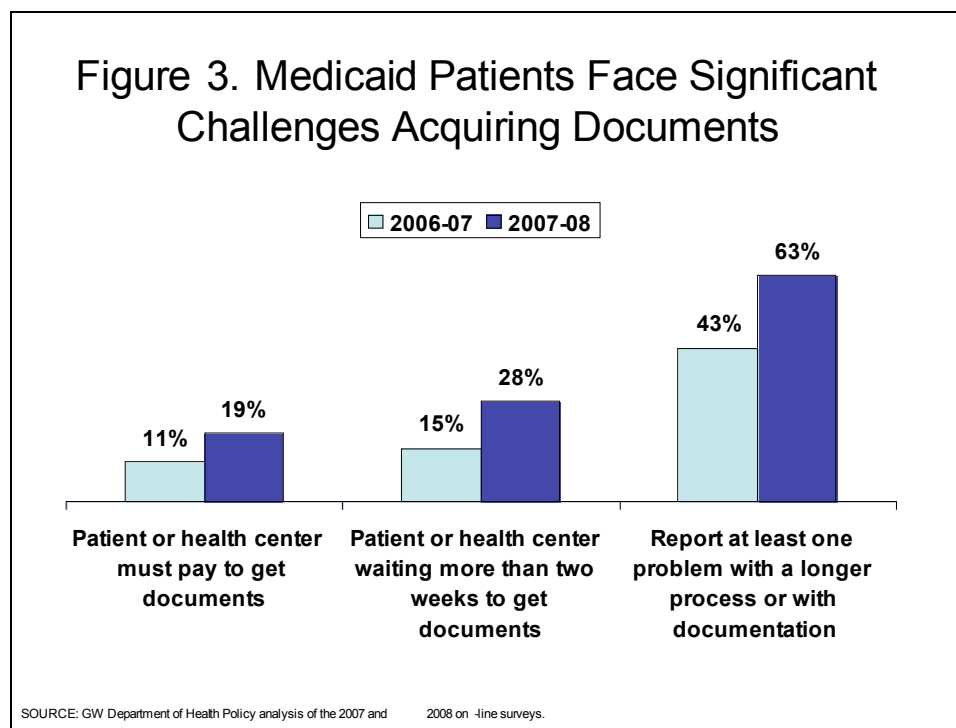
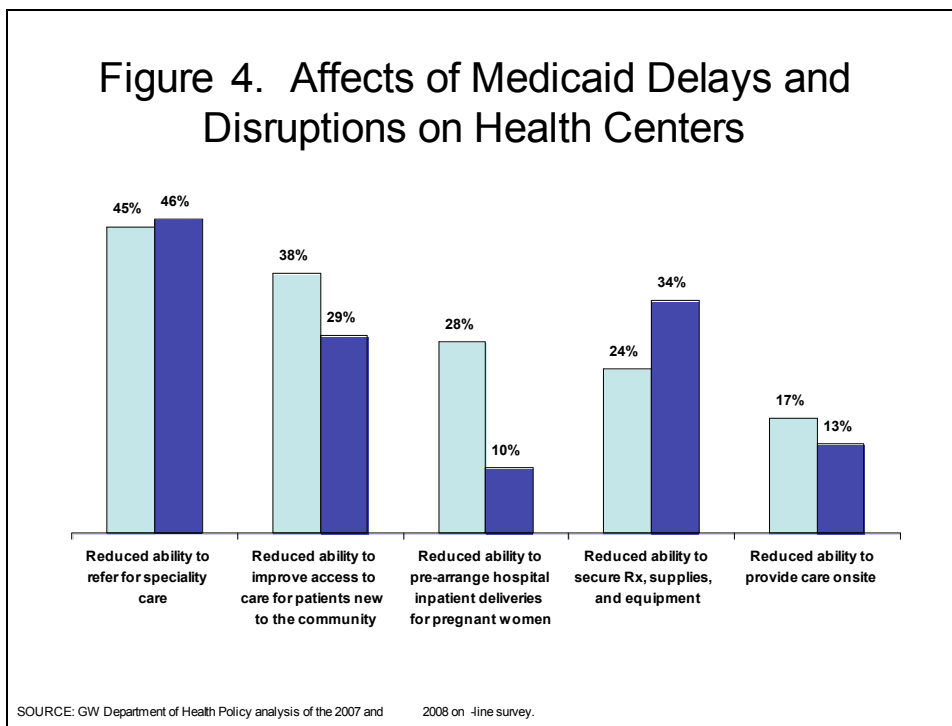


Figure 3 shows ongoing problems with securing documents, despite the fact that the list of qualified documents was somewhat expanded in the final rule. Sixty-three percent of health centers responding to the second wave study reported at least one problem with a longer application process or with documentation, compared to 43 percent in the first wave study. Nineteen percent of health centers indicated that applicants must pay to get documents, and 28 percent (compared to 15 percent one year earlier) reported waits of two weeks or longer to obtain necessary documents.



Many respondents reported that their staff were continuing to spend additional time assisting Medicaid applicants in obtaining necessary documents, with greater attendant costs. Reported increases in personnel time varied from five minutes to over three hours per application. Some health centers indicated that they hired new personnel to assist with the increased administrative load; in other cases, respondents reported that work burdens on existing staff simply were increased.

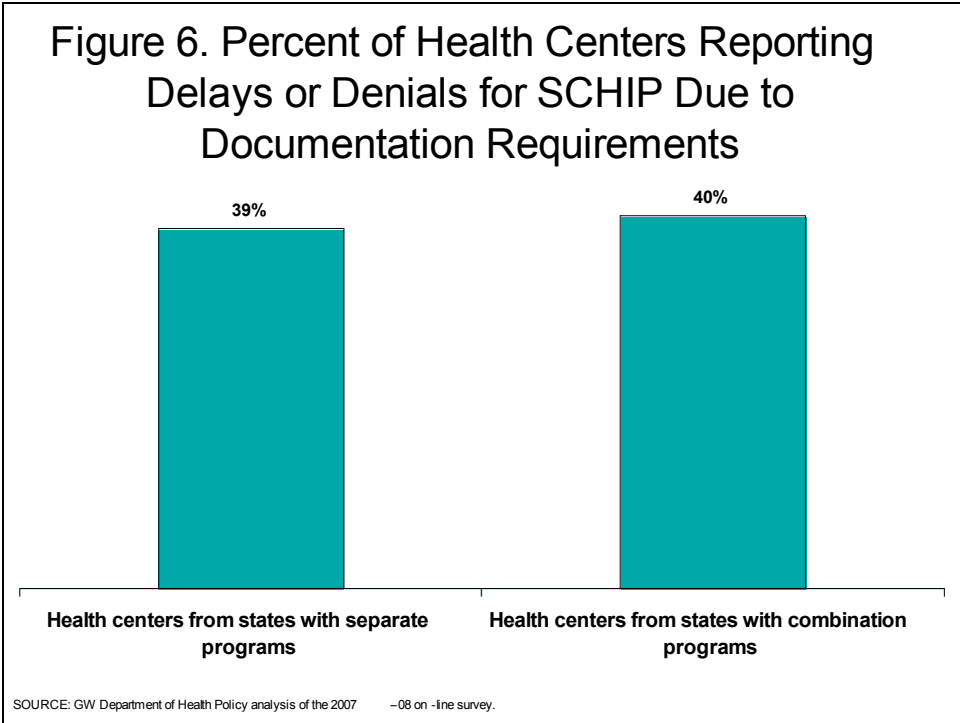
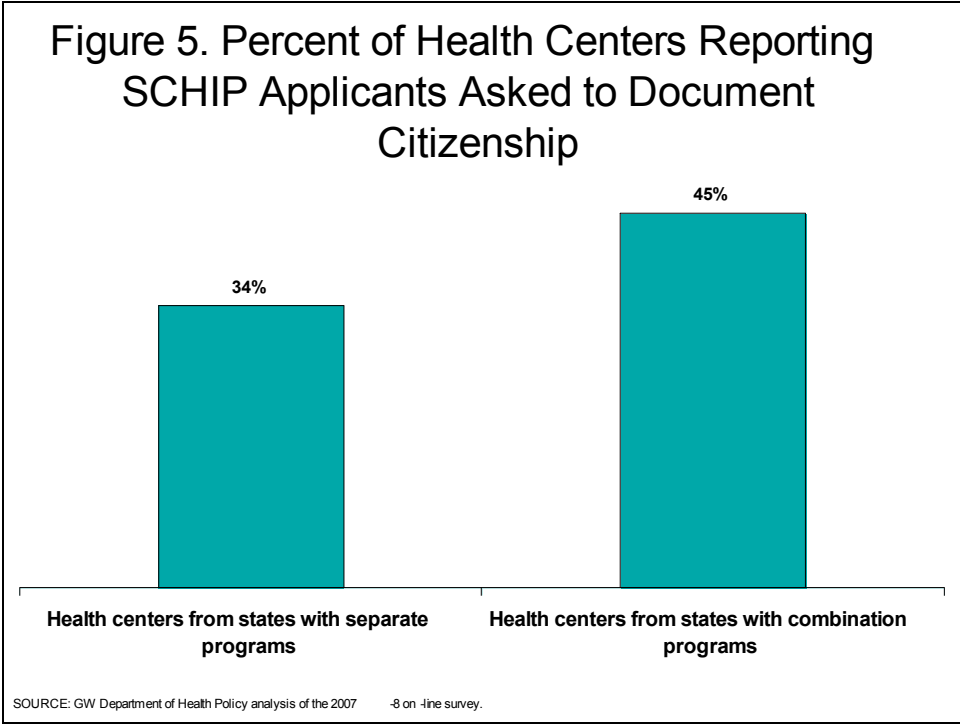
Health centers continued to report that the documentation requirements affected their ability to provide or arrange for care. Despite some improvement since the previous study, the “second wave” results shown in **Figure 4** indicate that interrupted or delayed Medicaid coverage has continued to affect health centers’ ability to arrange for specialty care. Forty-six percent reported reduced ability in arranging for specialty care (relatively unchanged from our previous study); 29 percent reported difficulties in securing health care for new patients (compared to 38 percent in the first wave); 10 percent reported difficulties in pre-arranging hospital inpatient deliveries for pregnant women (compared to 28 percent in the first wave study); and 34 percent reported difficulties in securing supplies and equipment, including prescription drugs (compared to 24 percent in the 2006-07 analysis). Finally, 13 percent of health centers also reported a reduced ability to provide care on-site.



Even as Medicaid delays and disruptions continued, patients remained eligible for care because of health centers' service mission. Thus, more than 73 percent of health centers reported that patients who lost Medicaid coverage for some period of time continued to receive services as "uninsured" patients. As a result, the delay and disruption in Medicaid coverage for uninsured but Medicaid-eligible patients had a spillover effect, depriving health centers of funding that otherwise would have been used to maintain or increase care for other uninsured but Medicaid-ineligible patients in their service areas.

One of the most surprising findings to emerge from this "second wave" study was the effect of the documentation requirements on State Children's Health Insurance Programs (SCHIP). Citizenship documentation rules do not apply to separately administered SCHIP programs; however, the screening and enrollment requirements of SCHIP mean that many states employ the same application forms for both SCHIP and Medicaid. **Figure 5** shows that one-third of health centers in states with separate SCHIP programs, and nearly half (45 percent) in states with combination programs, reported that parents were asked to document their child's citizenship when applying for SCHIP.¹⁶ **Figure 6** shows that in states with separate SCHIP programs, two in five health centers reported that SCHIP applications were being held up or denied because patients were unable to provide proof of citizenship; a proportion similar to that of health centers in states with combination programs.

¹⁶ As of June 2007, 19 states (AL, AZ, CO, CT, GA, KS, MS, MT, NV, NY, OR, PA, TN, TX, UT, VT, WA, WV, and WY) had separate SCHIP programs.



Discussion

Despite little evidence of unlawful utilization, the DRA Medicaid amendments impose strict citizenship documentation requirements for Medicaid applicants as part of the Deficit Reduction Act of 2005. The evidence suggests that these complex requirements have proven burdensome with little or no benefit realized. The results from this second wave study suggest that the changes implemented in the final rule appear to have done little to address the systemic problems experienced by health centers and low income patients, and that both are continuing to experience the effects that flow from coverage delays and interruptions. Health center patients not only continued to experience delays in coverage or unwarranted denials, but health centers themselves were then faced with increased practice difficulties and serious financial effects as they attempted to manage care for additional uninsured patients.

Other studies have documented the greater difficulties faced by health centers in securing access for their uninsured patients to necessary specialty care and other services not available at the health center.¹⁷ The evidence from this study suggests that the citizenship documentation requirements may worsen an already serious problem by interrupting Medicaid coverage essential to locating sources of specialty care. Of particular concern is the effects of the documentation requirement on pregnant women and newborns, whose need for rapid management can become a particularly acute matter.

Another distressing finding is the impact the citizenship documentation requirements appear to be having on SCHIP. Many states, for important reasons, use joint applications for both Medicaid and separate SCHIP programs. The effect, however, is to apply the citizenship documentation requirements to both programs, thereby delaying coverage for both groups of children.

The DRA's citizenship documentation requirements may also have negative implications and adverse health consequences for other forms of ambulatory health care used by safety net populations. Twenty-six states (26) have Medicaid waivers that expand family planning services for low-income women. CMS is requiring that citizenship documentation requirements be applied to these programs as well, even though the family planning benefit is very modest.¹⁸ In Oregon, within the first 12 months of implementation of the citizenship documentation requirements, utilization of family planning services in its waiver program fell by 30 percent overall and by 42 percent for teenagers.¹⁹ California's Governor Arnold Schwarzenegger has warned that the requirement threatens the

¹⁷ M.K. Gusmano, G. Fairbrother, and H. Park, "Exploring the Limits of the Safety Net: Community Health Centers and Care for the Uninsured," *Health Affairs* 21, no. 6 (2002): 188–194.

¹⁸ A. Sonfield, C. Aldrich and R.B. Gold, "State Government Innovation in the Design and Implementation of Medicaid Family Planning Expansions," New York: Guttmacher Institute, March 2008.

¹⁹ L. Angus, Oregon Public Health Division, "Effect of Medicaid citizenship documentation requirements in family planning waivers: First year observations," presentation at AcademyHealth conference, Washington, DC, Jun. 10, 2008.

renewal of that state's family planning Medicaid waiver, which serves close to 200,000 people at family planning clinics statewide. California estimates that implementation of these requirements would cost the state \$262 million in federal funds and could result in even higher costs as a result of additional unplanned pregnancies that might occur if women, including teenagers, are unable to obtain needed contraceptive services.²⁰

Patient coverage disruptions and losses have important implications for health care quality. As this study shows, the DRA continues to place a significant economic burden on health centers, resulting in diminished ability to provide key services, including patient referrals for specialty care and other services found outside the health center. In effect, the citizenship documentation requirements undermine the goal of creating health care homes for all patients, with the capacity to manage a full spectrum of health care needs.

²⁰ Gov. A. Schwarzenegger, Letter to Michael Leavitt, Secretary of Health and Human Services, dated Sept. 11, 2008

Appendix: Study Methodology

2007-08 National Survey

As part of the larger George Washington University Geiger Gibson Program (GW) research effort to understand the effects of the identification and citizenship documentation requirements on safety net providers, GW conducted an on-line survey to assess the impact of these requirements on health centers nationwide. The survey was administered to all 974 health centers nationwide between September 2007 and March 2008 – more than one year after implementation of the documentation requirements. With assistance from the National Association of Community Health Centers, state Primary Care Associations, health center networks, and community-based organizations, we received a response rate of 27 percent (260 responses). The response rate did not provide enough sampling for any state estimates. In addition, researchers at The George Washington University made phone calls to centers who had not yet responded encouraging them to complete the survey. Responses were received from 48 states and the District of Columbia.

The health centers which responded to this study closely resemble both the sample of health centers from the 2006-07 study as well as health centers nationwide in several key characteristics. The patients that utilize the responding health centers mirror the national population of health center patients' income, age, and race/ethnicity. Likewise, respondent health centers closely resemble the national population of health centers in terms of the payor source. The average number of patients served by the respondent centers was slightly higher than the average number of patients served at health centers nationally (15,779 versus 15,032 respectively), but slightly less than the average number of patients served at health centers in the 2006-07 study (16,259). Approximately 55 percent of the respondent health centers were located in rural areas, making the respondent health centers slightly more rural than the national average (52 percent), but slightly less rural than those that participated in the 2006-07 survey (57 percent).

In order to adjust for non-response, the results of the 2007-08 survey were weighted by size and geographic region to reflect the national sample of health centers in the 2007 UDS. Size was determined by the total number of patients served annually. Centers were categorized into three groups, less than 5,000 patients, 5,000 to 9,999 patients, and 10,000 or more patients. Health centers were placed into four geographic regions using the Census Bureau's Regions and Divisions. Regions include the following: Northeast, South, Midwest, and West.

2006-07 National Survey

The survey was administered to a random sample of 300 health centers between December 2006 and March 2007. With assistance from the National Association of Community Health Centers, state Primary Care Associations, health center networks, and community-based organizations, we received responses from 139 health centers representing 44 states. While additional providers responded to the survey due to aggressive public outreach, we included only those on the original list to ensure a valid sample. In order to minimize reporting bias, every effort was made to solicit responses from health centers regardless of whether they had experienced an impact. The final response rate was 46 percent, or 139 of 300 health centers.

The respondent health centers closely resemble health centers nationwide in several key characteristics. The income of patients served at responding health centers is virtually identical to the income of all community health centers. The insurance status of respondent health center's patients also closely mirrored the insurance status of patients at all community health centers. The health centers which responded to the survey had a slightly higher but not statistically different elderly population, with about 10 percent of their patients aged 65 or older compared to seven percent nationally. Likewise, respondent health centers served a smaller percentage of adults aged 20-64 and virtually the same percentage of children under age 20. Respondent health centers largely served the same percentage of patients from racial and ethnic groups as compared to all health centers, but served a slightly higher percentage of Asian and White patients and a slightly lower percentage of Black and Hispanic patients. Respondent health centers served a higher number of patients annually, with an average of 16,259 patients per year compared to 15,032 patients served at all health centers – a difference of only eight percent. Finally, a slightly higher percent of respondent health centers were located in rural areas than all health centers, with 57 percent versus 52 percent, respectively.