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Medicaid's New Documentation Requirements: How Are They Affecting Patients and Health Centers?

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Medicaid's New Documentation Requirements

About this Paper

Under the federal Deficit Reduction Act of 2005, most individuals eligible for Medicaid are required to document their U.S citizenship or residency status, as well as to prove their personal identity, before receiving the health care benefit. Although eligibility standards are otherwise unchanged, some of the nation's most vulnerable and medically underserved populations have lost Medicaid coverage as a result. It has also strained the system of federally funded community health centers, which provide high-quality, cost-effective care to 14 million people, many of them Medicaid beneficiaries or among the uninsured.

These findings are described in a new study, "[An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and their Patients](#)," issued through the Geiger Gibson Program in Community Health Policy at GW's School of Public Health and Health Services. RCHN Community Health Foundation provided funding for that report.

This Rapid Response paper describes the mandated changes in Medicaid documentation requirements and their impact.

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About the Rapid Public Health Policy Response Project

The Rapid Public Health Policy Response Project of the School of Public Health and Health Services at The George Washington University presents data and other background information on breaking public health stories. The goal is to educate the public, policymakers, legislators, health care providers, the media and others in order to promote informed decisionmaking. Karyn Feiden, an independent consultant who writes about public health and health care, provides editorial support for this project. Financial support comes from the Public Health and Policy Group of Pfizer, Inc.

Medicaid's New Documentation Requirements: How Are They Affecting Patients and Health Centers?

Federal law now requires most individuals to document their U.S. citizenship or status as legal residents, as well as their personal identity, in order to receive Medicaid. This mandate, incorporated into the Deficit Reduction Act of 2005, affects nearly all of the 28 million children who qualify for Medicaid, other than those who receive disability or child welfare benefits.¹ Most Medicaid-eligible adults (typically parents or caretakers of young children) are also affected, unless they are either elderly or disabled.

Since 1986, all Medicaid applicants have had to declare their legal status in writing, under penalty of perjury.² To be eligible, individuals who are not U.S. citizens have also had to prove they are in this country legally and have resided here for at least five years. That mandate has not changed. What is new is the requirement that citizens produce citizenship documents, and that all Medicaid applicants and beneficiaries produce identity documents.

The first systematic national assessment of the new requirements, undertaken by The George Washington University School of Public Health and Health Services, shows a two-fold impact:³

- ▶ Children and adults who had been receiving Medicaid are losing coverage. According to the study's conservative estimates, as many as 319,500 health center patients already enrolled in Medicaid are being dropped from its rolls. More than two-thirds of them are children.
- ▶ Community health centers, the nation's largest single source of primary health care for low-income and medically underserved individuals, have been placed in a more financially precarious situation. This reflects the tandem effects of declining numbers of Medicaid-enrolled patients and an increase in the number of uninsured seeking health care.

Documentation Requirements

Under the new law, Medicaid applicants must produce citizenship or residency documents when they first apply for Medicaid, or when they recertify their eligibility status, as they are required to do at least every year. The intention was to prevent illegal immigrants from lying about their status and receiving benefits, according to Congressman Nathan Deal (R-GA), who helped spearhead the legislation. Deal said the current system "is open to a great deal of fraud" because proof of citizenship has not been required.⁴

Implementing regulations established by the federal Centers for Medicare and Medicaid Services spell out a "hierarchy" of acceptable documents.⁵ In order to obtain the most

reliable evidence possible, the states are supposed to seek documents in a specific sequence. Only if “primary documents” — a U.S. passport or a certificate of naturalization — are not available can they accept “secondary” documents, such as a birth certificate combined with a personal identification document, such as a driver’s license. Criteria have also been established for third and fourth levels of evidence.

Many low-income people find it difficult to produce these papers.⁶ Cost can be a factor, especially for populations that are struggling to meet basic needs, such as housing and food. A U.S. passport is expensive to obtain and the more modest fees for birth certificates and identify documents are equally prohibitive for some. The need to navigate bureaucratic systems can also be a stumbling block, especially since Medicaid beneficiaries and potential beneficiaries must produce original documents or copies certified by the issuing agency. The implementing regulations of the new law require states to provide assistance and “reasonable opportunity” to secure the documents, but those concepts are not specifically defined.⁵

A distinctive feature of the new law is that states can not provide interim Medicaid coverage to applicants who are U.S. citizens while they gather the required documentation. This is so “even if they have made a sworn declaration that they are citizens, have met all Medicaid eligibility requirements and have applied for a passport or a birth certificate and are waiting to receive it,” according to the Center on Budget and Policy Priorities.⁷ It stands in contrast to the laws for legal immigrants, who are permitted to receive Medicaid as they complete the process of proving their eligibility.⁸

A few exceptions exist to the documentation requirements. Medicaid will cover emergency care, which is used almost exclusively to pay for childbirth and complications of pregnancy,⁹ to financially eligible individuals without documents. Individuals receiving Medicare, Social Security or Supplemental Security Income (SSI) benefits, generally adults, are also exempt, as are children receiving child welfare assistance, special needs foster care, and certain forms of adoption assistance.¹⁰

A clarification from the Centers for Medicaid and Medicare Services states that newborn infants born to women receiving Medicaid coverage, are themselves eligible for Medicaid for up to a year.¹¹ (The mothers must actually be receiving emergency or regular Medicaid coverage; if their applications are pending, their newborns will not be covered.) After a year, citizenship documents must be produced to recertify the infant for Medicaid.

In practice, the effects of the new law are falling primarily on children and their parents.

The Role of Community Health Centers

The recent changes in Medicaid policy are having a significant impact on the nation’s community health centers, which in 2005 received 36 percent of their operating revenues in the form of Medicaid reimbursement.¹²

The central mission of the nation’s 1,000 health centers is to provide health care to anyone who seeks it, regardless of their ability to pay. They are the family doctor and health care home to more than 14 million people — including five million Medicaid

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beneficiaries — in more than 5,700 communities across the country, according to 2005 data from the National Association of Community Health Centers.¹³

Health centers play a central role in providing primary care to low-income and medically underserved populations. As well, virtually all the centers help patients complete and file the applications necessary to secure Medicaid coverage. The growing demand for their services — patient visits increased by 45 percent from 2000 to 2005 — comes especially from the most vulnerable Americans:¹⁴

- ▶ More than 90 percent of health center patients live at or below 200 percent of the federal poverty level.
- ▶ Two-thirds of patients who receive care at health centers belong to racial and ethnic minority groups.
- ▶ About 36 percent of health center patients have Medicaid coverage. Another 40 percent are uninsured.

Nationwide, health centers provide care to:

- ▶ One in every nine Medicaid beneficiaries.
- ▶ One in every eight individuals without health insurance.
- ▶ One in seven members of minority groups.
- ▶ One in 10 rural Americans.

Moreover, health centers provide care that is in general more comprehensive, more prevention-oriented and more cost-efficient than most care available to this population. For example:

- ▶ Medicaid patients treated at health centers have lower rates of avoidable hospital admissions, fewer avoidable emergency room visits, and shorter hospital stays.¹⁵
- ▶ Uninsured patients who visit health centers are twice as likely to get the care they need as other uninsured populations (based on measures of delays in getting needed care; going without care altogether due to cost; and failure to fill prescriptions).¹⁶
- ▶ Adults who get their care at health centers are more likely to have discussed smoking and physical activity with a provider than adults who are privately insured.¹⁷

Just as health centers are a critical resource for Medicaid-eligible individuals, so too is Medicaid revenue essential to the operations of the health centers.

Health centers operate on negligible margins and rely in part on federal appropriations to supplement third-party payments, which are less than the cost of the care the centers provide.¹⁸ Medicaid, however, is a fairly generous payor, covering almost 87 percent of health center charges (Medicare, by contrast, reimburses 69 percent of charges for its patients while private insurance covers 58 percent.)¹⁹



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Any loss of Medicaid revenue is therefore likely to have direct implications for the accessibility and quality of care available at health centers.

Assessing the Impact

Researchers at GW's School of Public Health and Health Services conducted an on-line national survey of 300 randomly selected health centers to assess the impact of the new documentation requirements for Medicaid eligibility on the program's beneficiaries and on the health centers that serve them.³ Based on responses from 139 health centers in 44 states:

- ▶ Most health centers (92 percent) are having difficulty enrolling at least one category of patients — including parents, pregnant women, children and newborns — into Medicaid.
- ▶ Almost half (43 percent) of the health centers say the Medicaid process has become more difficult, either because the application or enrollment process is taking longer or because the required documents can not be readily secured. More than one-third of health centers report dedicating additional staff time to assist patients.
- ▶ More than 20 percent of all health centers are seeing a drop in Medicaid patients, and the new citizenship and identity requirements are emerging as the single most important cause. “Given the growth of Medicaid patients at health centers over the past two decades, any decline tends to signal a Medicaid barrier,” says Peter Shin, lead author of the GW study.
- ▶ More than 60 percent of the health centers are now providing health care to patients who once had Medicaid, but lost their coverage. Along with shouldering the increased expenses of a newly uninsured population, health centers are finding it more difficult to arrange specialty care or hospital inpatient deliveries for its uninsured population.

The GW researchers also designed an impact analysis to measure the effect of the new documentation requirements.³ That generated the estimate that as many as 319,500 current Medicaid beneficiaries — 212,400 children and 107,100 adults — who receive their care at health centers will lose coverage, at least temporarily. The methodology used in the analysis (described in detail in the report) almost surely understates the impact, perhaps quite dramatically, in part because it excludes newborns and does not consider the impact on new Medicaid applicants.

“These findings suggest that the legislative requirements are adding significantly to the burden of Medicaid enrollment,” said Sara Rosenbaum, chair of the GW Department of Health Policy and a co-author of the new study.

Assuming the disruptions in a health center patient's Medicaid coverage last an average of six months — again, a conservative assumption, given the challenges of producing

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documentation — the centers are facing an immediate loss of up to \$85 million in Medicaid revenue.³ They are also likely to face additional costs as they dedicate more resources to helping patients produce documents and complete their Medicaid applications. A further burden — as yet uncalculated — is the costs of caring for the uninsured patients who are turning to the health centers in growing numbers when they lose Medicaid, and with it their usual source of care.

According to the GW study, an \$85 million cut in the overall budgets of health centers could mean a choice among these options:

- ▶ Serving 166,000 fewer uninsured patients.
- ▶ Laying off 340 health professionals (including physicians, nurses, dental professionals, pharmacists and mental health professionals).
- ▶ Eliminating more than 130 planned new health centers in the nation's poorest counties.
- ▶ Reducing resources to respond to emergencies, such as those encountered after Hurricane Katrina, where the health centers played a vital role.

“Health centers are experiencing a significant rise in their costs — especially in the cost of the assistance they offer to help patients gain coverage in programs for which they qualify — amid a notable drop in their revenues,” said Dan Hawkins, a top official with the National Association of Community Health Centers.

Policy Options

The law's expressed intent was to bar illegal immigrants from Medicaid coverage. However, in a report issued prior to the bill's passage, the Office of the Inspector General at the Department of Health and Human Services found no substantial evidence that undocumented immigrants are committing fraud in order to receive coverage.²⁰ The actual impact has been the reverse — low-income American citizens are the ones facing new barriers.

The National Association of State Medicaid Directors has called the results of the new law “burdensome,” increasing state costs in the form of paperwork, application backlogs and staff training time. In an Issue Background piece, the association also notes that the denial of Medicaid services to otherwise-eligible citizens was clearly “not the intended outcome of this new statutory provision.”²¹

The state Medicaid directors, and other local, state and national organizations have advanced proposals to redress these unintended consequences.²² Their recommendations, and those of other researchers, include:

- ▶ Revisiting the question of what qualifies as acceptable citizenship and identity documents.
- ▶ Eliminating the requirement for identity documents, which was not actually a feature of the Deficit Reduction Act itself, but of the implementing regulations developed by the Centers for Medicare and Medicaid Services.



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- ▶ Reducing the difficulties and cost associated with producing documents, including permitting the use of copies.
- ▶ Financing the cost to health centers and other safety net providers of providing support to Medicaid applicants.
- ▶ Extending coverage to applicants who are otherwise eligible for Medicaid pending their submission of the required documents.
- ▶ Returning to the policies in place prior the passage of the Deficit Reduction Act, when citizens were required only to affirm their status under penalty of perjury.

Income eligibility for Medicaid has not changed, but it has become more difficult for qualified people to get the benefits to which they are entitled. Meanwhile, the resources available to community health centers are shrinking as demand for their services grows. The result is an increase in the number of the uninsured and reduced access to primary care.

Notes on Sources

- ▶ 1. 42 U.S.C. §1396b(x) added by §6036(a)(2), P.L. 109–171 (109th Congress, 2d Session).
- ▶ 2. 42 U.S.C. §1396b(i)(22).
- ▶ 3. Shin PA., et al., [An Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients](#),” Department of Health Policy, The George Washington University School of Public Health and Health Services, May 7, 2007. Issued through the School’s Geiger Gibson Program in Community Health Policy. RCHN Community Health Foundation provided funding for that report.
- ▶ 4. Moscoso E, [“Medicaid Proof Of Citizenship Requirement Could Hurt Poor, Critics Say,”](#) Cox News Service, Jan. 21, 2006.
- ▶ 5. The interim final rule issued by the Centers for Medicare and Medicaid Services to implement the Deficit Reduction Act amendments to Medicaid is contained in 71 Fed. Reg. 39214 (July 12, 2006). These rules are well-explained by Solomon J, Schneider A, [New HHS Regulations Focus Medicaid Documentation Requirement on U.S. Citizen Families](#). Center on Budget and Policy Priorities, Washington, D.C. July 2006.
- ▶ 6. The potential obstacles to obtaining or replacing citizenship documents is described in Boozang P, Dutton M, Hudman J, [“Citizenship Documentation Requirements in the Deficit Reduction Act of 2005: Lessons from New York.”](#) Kaiser Commission on Medicaid and the Uninsured, June 2006.
- ▶ 7. Solomon J, Schneider A, [“New HHS Regulations Focus Medicaid Documentation Requirement on U.S. Citizen Families.”](#) Center on Budget and Policy Priorities, Washington, D.C. July 2006.
- ▶ 8. Section 1137(d)(4) of the Social Security Act.
- ▶ 9. DuBard CA and Massing MW. [“Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants.”](#) *Journal of the American Medical Association*, March 14, 2007;297:10 1085–1092.
- ▶ 10. The additional exemptions were included in the Tax Relief and Health Care Act (P.L. 109–432, 109th Congress, 2d Session).
- ▶ 11. Centers for Medicare and Medicaid Services, [“All Low Income Newborns to Receive Equal Access to Medicaid.”](#) Press release, March 20, 2007.

- ▶ 12. National Association of Community Health Centers. Figure 1.4, “A Sketch of Community Health Centers,” *Chart Book*, 2006.
- ▶ 13. See [Health Center Fact Sheet](#) and the Web site of the [National Association of Community Health Centers](#).
- ▶ 14. Figure 2.1 in “A Sketch of Community Health Centers” provides data on growth in patient visits to health centers. Figures 1.1 to 1.4 in that *Chart Book* show the demographic and socioeconomic data of center patients. These data are also well-summarized in the [Health Center Fact Sheet](#).
- ▶ 15. Falik et al. “Comparative Effectiveness of Health Centers as Regular Sources of Care,” *Journal of Ambulatory Care Management*, 29(1):24–35. 2006. Falik et al., “Ambulatory Care Sensitive Hospitalizations and Emergency Visits: Experiences of Medicaid Patients Using Federally Qualified Health Centers.” *Medical Care* 39(6)551–56. 2001. Duggar BC, et al. “Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers.” Center for Health Policy Studies. 1994. Duggar BC, et al. Utilization and Costs to Medicaid of AFDC Recipients in New York Served and Not Served by Community Health Centers.” Center for Health Policy Studies. 1994. Data from these sources are summarized in Figure 6.1, “A Sketch of Community Health Centers.”
- ▶ 16. Politzer R. et al., “Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care,” *Medical Care Research and Review* 58(2)234–48. 2001. Data from this source are summarized in Figure 3.4, “A Sketch of Community Health Centers.”
- ▶ 17. Leiyu S., “The Role of Health Centers in Improving Health Care Access, Quality and Outcome for the Nation’s Uninsured,” Congressional testimony to the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee, May 25, 2005. This testimony was based on the Community Health Center User Survey, 2002 and the National Health Interview Survey, 2002. Data from this source are summarized in Figures 4.6, 4.7 and 4.8 in “A Sketch of Community Health Centers.”
- ▶ 18. Based on an analysis of 2006 Uniform Data System (UDS), the system used by all federally-funded health centers to report to the federal Health Resources and Services Administration. See Figure 7.4 “A Sketch of Community Health Centers.”

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- ▶ 19. Based on an analysis of 2006 Uniform Data System (UDS). See Figure 7.3, [A Sketch of Community Health Centers](#).
- ▶ 20. Office of the Inspector General, [Self-Declaration of U.S. Citizenship for Medicaid](#). July 2005.
- ▶ 21. National Association of State Medicaid Directors and the American Public Human Services Association. Issue Background, "[Medicaid Citizenship Documentation](#)." April 2007.
- ▶ 22. Twenty national organizations — including the American Nurses Association, the American Public Health Association, Families USA, and the National WIC Association — made many of these policy recommendations in a [letter to the Centers for Medicare and Medicaid Services](#) in August 2006, when the Medicaid documentation requirements were proposed. Eighty local and state organizations — including local branches of Legal Aid and the Gray Panthers and AIDS and cancer patient advocacy groups — also sent a [letter with recommendations](#).