GETTING AND KEEPING COVERAGE: STATES' EXPERIENCE WITH CITIZENSHIP DOCUMENTATION RULES

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ABSTRACT: Federal regulations, which took effect in mid-2006, require that individuals provide proof of citizenship when applying for or renewing coverage under public health insurance options such as Medicaid. This report examines the impact that these citizenship documentation rules have had on coverage stability in the public programs of seven states—Alaska, Arizona, Kansas, Louisiana, Ohio, Virginia, and Washington—and it finds that the rules have made the getting and keeping of children and families' coverage more difficult. The new requirements increased the complexity, administrative burden, and costs of enrollment and renewal in each state, and in some cases the rules even compromised other processes. The rules' specific effects on applicants and enrollees differed in each state, depending on the state's circumstances, its approach to implementing the rules, and its organizational and technological capacity. But some of the positive activity that occurred can be replicated elsewhere and extended.

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EXECUTIVE SUMMARY

Until the nation adopts a comprehensive national strategy on health insurance coverage, it is imperative that current public health insurance programs provide low-income Americans with stable and effective coverage options. For beneficiaries of public programs like Medicaid, stable health coverage is associated with better access to appropriate cost-effective care; for states, health plans, and providers, it is associated with lower administrative costs. Yet some public program features can undermine these objectives—for example, by requiring individuals to provide proof of citizenship and identity when applying for or renewing benefits, as federal Medicaid rules adopted in mid-2006 specify.

This report examines the impacts that citizenship documentation rules have had on coverage stability in seven states' public programs for children and families. It finds these rules have made it harder for many people to obtain and keep public health insurance coverage. The requirements have increased the complexity, administrative burden, and costs of enrollment and renewal in each state—in some cases curtailing ongoing efforts to simplify processes, as resources were diverted for citizenship documentation purposes. The rules' specific effects on applicants and enrollees, however, differed in each state, depending on the state's circumstances, the approach it took in implementing the rules, and its organizational and technological capacity.

In **Alaska,** the human impact of the rules has been clearly evident. Enrollment among Alaska Native children, all of whom are citizens, declined by more than 10 percent in the six months following the policy change. The need to present original documents complicated not only applications but also renewals; the latter are processed primarily by mail, but families have been reluctant to send original documents in this manner. The state estimates that processing costs increased by $8.25 for each application and $7.00 for each renewal, reflecting additional time spent by eligibility workers and clerks as well as increased copying and postage costs. There was more stress on the Alaskan eligibility system in the early months of the new policy than in most other states, because eligibility certifications for children are conducted in Alaska twice as often (every six months, as opposed to annually). As many as 54 percent of cases were closed at renewal in the six months following the policy change, and extra administrative costs were incurred for cases that were closed and then reopened.

Arizona is one of a handful of states whose legislature provided funds for implementing the citizenship documentation rules. An allocation of $10.4 million was used to help procure documents, place staff in Medicaid office lobbies to copy documents, train eligibility workers, and establish a troubleshooting unit to solve

problems related to citizenship documentation. The state saw little change in enrollment. By the fall of 2006, however, less than half of Arizona KidsCare applications were processed in a timely manner, down from 70 percent at the beginning of the year. This was likely the result not only of citizenship documentation requirements but also of other factors: conversion to a new eligibility system, high staff turnover, implementation of a new family premium structure, and a community outreach campaign. To process applications more efficiently, the state piloted the use of electronic applications and a "virtual office" program that allows some eligibility workers to work from their homes.

Kansas reported a substantial decline in enrollment for HealthWave, which includes both the Medicaid and SCHIP programs, after the citizenship documentation rules were implemented. The decline was much greater for non-Hispanic than Hispanic enrollees. Hispanic citizens may recognize, as a practical matter, that it is useful to have citizenship documents available. In the months after the policy change, the state had to establish backlog policies for the first time; the proportion of applications pending had held steady at one or two percent for the first half of 2006, but by four months after the change it had climbed to 46 percent. The backlog eased somewhat when the state stopped requiring citizenship documentation for SCHIP applicants, and it was later reduced considerably when $1.2 million provided by the legislature was used to add 13 new staff for processing applications and renewals.

Over the past several years **Louisiana** made the stability of coverage for Medicaid enrollees a high priority even as the state was struggling to recover from Hurricane Katrina. But the citizenship documentation rules posed new challenges. Whereas the state had made steady progress in reducing coverage gaps for children, the proportion of children with gaps now increased. Before the new policy went into effect, only about a third of renewals required the use of paper forms—the state routinely conducts simpler and less costly telephone or "ex parte" renewals, which use existing and readily available information—but after the documentation requirements took hold (in July 2006) forms were required for 43 percent of renewals. Changes to simplify the renewal process had kept the closure rate at renewal close to 10 percent throughout 2005 and early in 2006, but the rate reached a high of 23 percent in October 2006. Louisiana was better prepared than many other states when citizenship documentation rules came into play because it already used an electronic case record system. Eligibility workers had real-time access to vital records, and they were already scanning and saving documents electronically. The state could review procedural closings, sorted by eligibility worker, to determine where additional training and technical assistance could be most useful; after such interventions, the proportion of procedural closings at renewal decreased substantially. Officials in Louisiana also note that the electronic system has reduced administrative costs.

After the citizenship documentation rules took effect in **Ohio,** monthly enrollment reports showed both a decrease in the number of new members approved for coverage and an increase in the number of enrollees leaving the program at renewal. Moreover, the proportion of pending applications and renewals grew. Officials estimate that in the state's Child and Family Coverage Medicaid program, administrative costs associated with the first year of the new rules exceeded $8.5 million. Because no additional funds were appropriated, implementation of the rules entailed resources that had been intended for other activities.

Medicaid enrollment in **Virginia** increased every year from 2003 through 2007, with the exception of 2006, when citizenship documentation rules were implemented. The data also show that—again, with the exception of 2006—enrollment grew in the fall, when outreach campaigns coincided with the start of school. As elsewhere, Hispanics were less affected by the new rules than others in Virginia. In focus groups conducted shortly after the rules' implementation, eligibility workers reported that parents had more questions than usual regarding the application process as well as the options available should their children need health care services while waiting to be enrolled. In response to a telephone survey, 40 percent of parents whose children needed health care during these periods reported that the kids did not get all the care they needed. Parents who did seek care for their children at such times said they were more likely to go to emergency departments, drop-in facilities, and health centers or clinics and less likely to use a private doctor's office than when their children are covered. These findings suggest that continuity of care may have been compromised and that at least some young patients received care in costlier-than-usual settings.

Several factors likely contributed to the relatively stable enrollment in **Washington** following implementation of the citizenship documentation rules. Some $2.6 million in state and federal matching funds had been allocated to the process; a Citizenship Central Unit was established to help current and potential program participants document citizenship; and the state conducted electronic "batch" matches, four times in the first year, to find birth certificates for applicants and enrollees. Batch matches accounted for more than three-quarters of verifications. This approach not only promoted coverage stability but also saved a great deal of time for workers in the field and at the Central Unit. Eligibility workers continue to have access to information online for in-state birth certificates.

This study primarily focuses on the consequences, in seven states, of implementing the citizenship documentation rules. But the research is also pertinent to any policy that increases the complexity of the enrollment and renewal processes, thereby making it more difficult for individuals to obtain and keep public coverage.

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INTRODUCTION

Until the nation adopts a comprehensive national strategy on health insurance coverage, it is imperative that current coverage options are as stable as possible, providing easy access to appropriate cost-effective care for beneficiaries and incurring modest administrative costs for states, health plans, and providers.

Yet some program features are not compatible with promoting stability. In particular, a provision in the Deficit Reduction Act of 2005 requires individuals to provide proof of citizenship when applying for or renewing Medicaid benefits. And although this requirement does not apply to the State Children's Health Insurance Program (SCHIP) program, some states require that applicants for SCHIP provide citizenship documents as well.

Most states officially implemented the citizenship documentation requirement on July 1, 2006. But actual implementation was delayed in some cases because the states had had very little time to make operational changes; federal guidance was issued just three weeks before the law was to take effect.[1] From early on, however, state officials were apprehensive, noting that the policy could complicate the application and renewal processes for all Medicaid participants and increase the programs' administrative costs.[2]

This report examines the impacts of the citizenship documentation rules on coverage stability in seven states' public programs for children and families. It incorporates information provided by state officials about local circumstances and program policies, and it analyzes each state's data related to program application activity, enrollment, service use, and administrative costs for the periods immediately prior to and following implementation of the citizenship documentation rules (see About This Study, page 20). The seven study states and their populations of interest are described in Table 1.

The study shows that concerned officials had been prescient: the citizenship documentation rules indeed complicated individuals' efforts to obtain and keep coverage, and substantial resources were required from states to implement and follow the rules. In some cases, ongoing efforts to simplify enrollment and renewal and to promote coverage stability had to be curtailed as resources were diverted for citizenship documentation purposes. The study also shows that the different decisions that states make about how to implement federal program policies can have very different effects on day-to-day

operations and access to benefits. States determined when to implement the rules with regard to applications and renewals, how long a grace period to give current enrollees who could not produce the required documents but were otherwise eligible, how much assistance to give in obtaining and paying for documents, how much training and backup to provide for eligibility workers, how extensively to work with community partners, and (in the absence of any special federal funding to implement the rules) whether to appropriate funds. Faced with the new rules, some states developed policies and practices that were useful in the short term and could be adopted more broadly to improve other policies and practices that affect coverage stability.

Table 1. Medicaid and SCHIP Eligibility and Enrollment for Children and Parents in Seven States

State	Programs*	Groups covered (Income as % of the federal poverty level)	Implementation date for citizenship documentation	Baseline enrollment for groups most affected**
Alaska	Medicaid (Denali KidCare)	Children (175%) Parents (81%)	August 2006	42,741 (Medicaid children)
Arizona	Medicaid (AHCCCS) SCHIP (KidsCare)	Children (200%) Parents (200%)	July 2006	678,466 (Medicaid and SCHIP children and parents)
Kansas	Medicaid (HealthWave) SCHIP (HealthWave)	Children (200%) Parents (34%)	July 2006	125,210 (Medicaid and SCHIP children)
Louisiana	Medicaid (LaCHIP)	Children (200%) Parents (20%)	July 2006	665,770 (Medicaid children)
Ohio	Medicaid (CFC-Child and Family Coverage)	Children (200%) Parents (90%)	October 2006	1,327,911 (Medicaid children and parents)
Virginia	Medicaid (FAMIS Plus) SCHIP (FAMIS)	Children (200%) Parents (31%)	July 2006	387,074 (Medicaid children)
Washington	Medicaid (Family and Children's Medical Programs), SCHIP	Children (250%) Parents (76%)***	July 2006	510,487 (Medicaid and SCHIP children)

* Some states have opted to operate separate Medicaid and SCHIP programs (Arizona, Kansas, Virginia, Washington). Others have expanded Medicaid programs to cover more children (Alaska, Louisiana, Ohio).

** Enrollment in the month before the policy change is used as the baseline. Enrollment numbers represent data available from the state for the groups most affected by the policy, children as well as parents in states with expanded coverage (Arizona and Ohio).

*** A state-funded program in Washington covers parents with incomes below 200% of the FPL.

Enrollment declined in all seven states during the six months that followed implementation of the citizenship documentation rules. By comparison, enrollment had not changed substantially in the six months preceding the change. Twelve months after implementation, enrollment in six of the seven states was still lower than it had been in the prior period. The magnitude of enrollment change varied among the seven states, but the consistent pattern suggests that the citizenship documentation rules had a negative

impact on enrollment. A detailed look not only at the numbers enrolled in each state but also at local circumstances and program policies provides a broader understanding of how the requirement has affected program operations as well as applicants and enrollees.

Citizenship Documentation Requirements for Medicaid

As of July 1, 2006, most individuals applying for Medicaid or renewing coverage for the first time must document their citizenship. Certain groups are exempt from this requirement; they include individuals receiving both Medicare and Medicaid, Medicaid beneficiaries whose eligibilities are based on their receipt of Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), and children in foster care.

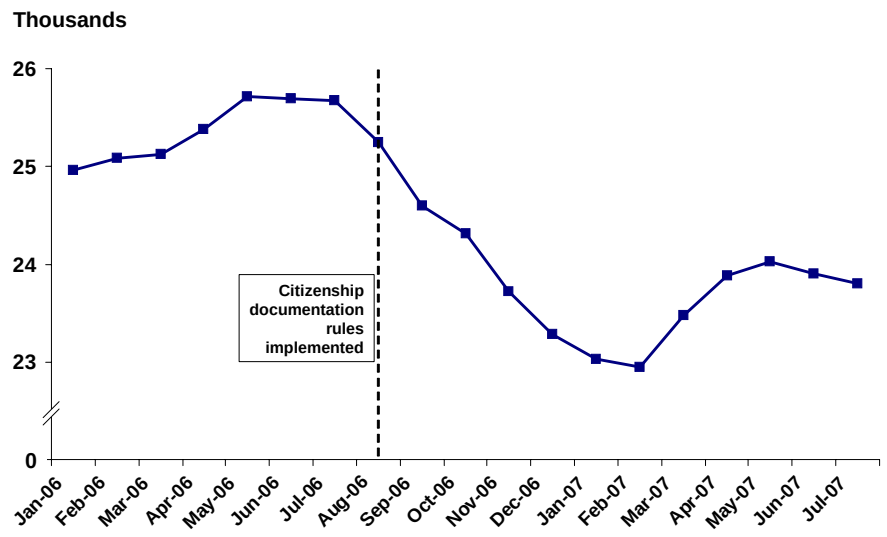
States were given the leeway to allow current Medicaid enrollees a "reasonable opportunity" at the time of renewal to verify their citizenship; coverage can continue while enrollees demonstrate that they are making a good-faith effort to provide the required documents. Medicaid *applicants* can also be given a reasonable opportunity to provide documentation before Medicaid eligibility is denied, but they cannot receive Medicaid coverage until they verify their citizenship. Newborns of women with Medicaid coverage are also eligible for Medicaid, but citizenship must be verified at the infants' first Medicaid renewal. In addition, pregnant women, children, and women eligible for breast-cancer and cervical-cancer screening may be granted presumptive eligibility for coverage, at state option, but they must document citizenship when filing a regular Medicaid application.

The regulations issued by the U.S. Centers for Medicare & Medicaid Services (CMS) define four levels, or tiers, of documentation, with the mandate that states seek the highest tier possible. Tier One is a U.S. passport, a Certificate of Naturalization, or a Certificate of U.S. Citizenship. Tier Two is a birth certificate or other specified record. Tier Three includes hospital, insurance, school, or religious records, and Tier Four specifies documents, as a last resort and subject to rigorous conditions, such as written affidavits. For all but the first tier, documents for proving identity—a driver's license or government-issued ID card, for example—are also required. Only original documents, or those certified by the issuing agency, are acceptable. States must make copies of the documents for each applicant or beneficiary and keep these copies on file.

Alaska

In the six months prior to implementation of the citizenship documentation requirement, enrollment in Alaska's Medicaid (Denali KidCare) program was fairly stable, with a modest decline of less than one percent. But six months after the change, enrollment had declined by 14 percent, the largest decrease among the study states. Alaska saw a 10.6-percent drop in enrollment among Alaska Native children, all of whom are citizens (Figure 1). The need for Medicaid applicants and enrollees to show original birth certificates posed a particular problem for Native Americans, who could produce original tribal documents more easily. Final rules allowed Native American tribal-enrollment cards to be used as proof of citizenship, but those rules were not issued until a year after the citizenship documentation requirement took effect.

Figure 1. Denali KidCare Enrollment for Alaska Native Children
January 2006–July 2007

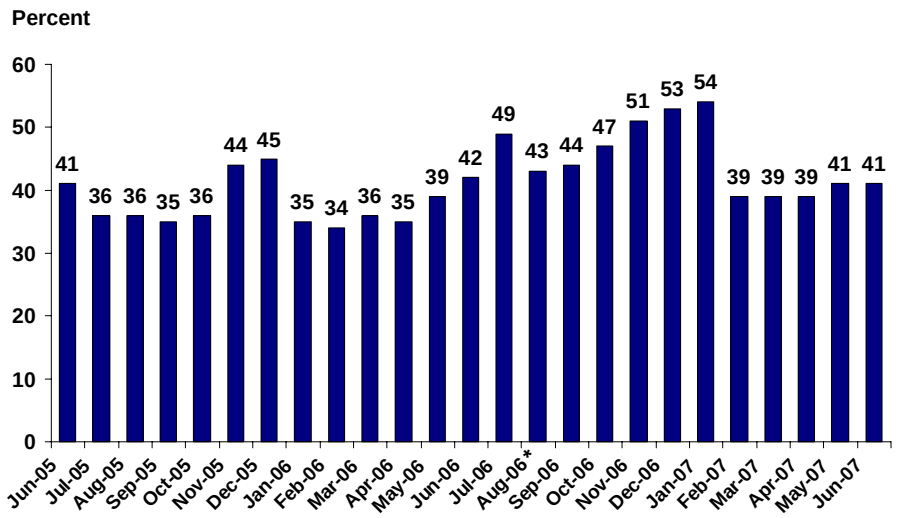


Source: Alaska Department of Health and Social Services, 2007.

The need to present original documents complicates the process considerably across the state. Because applicants and enrollees would have to travel long distances to reach Medicaid offices, the application and renewal processes are done primarily by mail. But some families are reluctant to trust the mail with their original documents.

In Alaska, eligibility certifications for children are conducted twice as often as in most other states (every six months, compared to annually). Thus children have twice as many opportunities to lose coverage if problems occur at recertification; moreover, the state experienced more stress on the eligibility system during the early months of the new policy than did most other states. In Alaska, where the closure rate at renewal already was high (at 43 percent) before the citizenship documentation policy change, as many as 54 percent of cases were closed at renewal in the six months following the policy change (Figure 2). Those months also had the highest rates of denial for applications relative to other months.

Figure 2. Denali KidCare Cases Closed at Renewal
June 2005–June 2007



* Citizenship documentation rules implemented.
Source: Alaska Department of Health and Social Services, 2007.

Considerably more administrative resources are devoted to recertification in Alaska than in other states, given that the process occurs twice as often, and state data indicate that it spent more than $600,000 just in preparing to comply with the citizenship documentation rules.[3] Estimates from state officials indicate that processing costs rose $8.25 for each application and $7.00 for each renewal, reflecting additional time spent by eligibility workers and clerks as well as greater copying and postage costs. It is important to note, however, that these extra costs pertain only to applications and renewals that were successfully processed; further administrative costs were incurred for disenrolling or reenrolling beneficiaries. One other difficulty noted by state officials is that promotions are not possible for eligibility workers. Turnover is higher as a result, especially among more experienced staff who might seek to advance professionally. Thus even as eligibility rules become more complicated, fewer experienced workers are available in Alaska to implement them.

Arizona

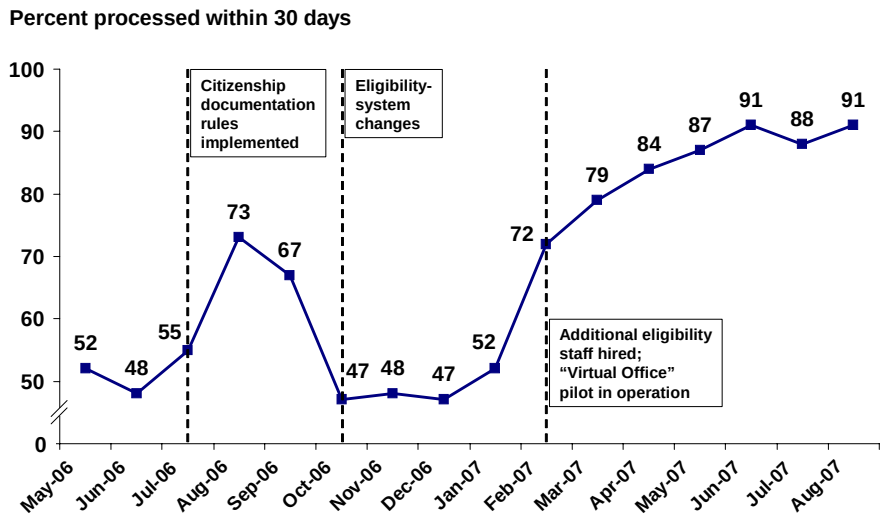
There was almost no difference in enrollment patterns between the six-month periods before and after implementation of the citizenship documentation rules in Arizona, where the new rules apply both to Medicaid (Arizona Health Care Cost Containment System, or AHCCCS) and SCHIP (KidsCare).

The provision of state funds to implement citizenship documentation rules likely contributed to the steady enrollment. The Arizona legislature allocated $10.4 million, including $6.8 million for the Department of Economic Security (DES) to establish a troubleshooting unit that aids applicants who encounter difficulties related to citizenship documentation and helps active members comply at renewal. The stated goal in Arizona has been to ensure that current enrollees who are otherwise eligible retain coverage. Toward that end, state officials review all problematic cases and assist individuals in obtaining proper documents; some $1.2 million helped cover the cost of citizenship documents that the state helped procure.

Moreover, $2.4 million helped routine operations proceed smoothly as they became more complicated. For example, more than 30 clerical staff were initially stationed in lobbies at local DES offices in order to copy documents. Also, each of 1,600 local eligibility staff participated in a one-day training session. The request for funds from DES to the Arizona legislature was based on the department's projection that average interview time would increase by 15 minutes. CMS had estimated in its guidance to states that an extra five minutes per application would be required,[4] but estimates from states were much higher.[5]

In Arizona, KidsCare applications are considered timely if they are processed in 30 days or fewer. But the proportion of such applications decreased substantially after the citizenship documentation rules were implemented in July 2006. By the fall of that year, less than half of Arizona KidsCare applications were processed in a timely manner, down from 70 percent at the beginning of 2006. This outcome likely resulted not only from the citizenship documentation requirements but also from the state's conversion to a new eligibility system, high staff turnover, and a new family premium structure. In addition, very effective outreach campaigns had been underway in the community. But the state assigned additional eligibility staff in February 2007 and conducted pilot projects designed to increase worker productivity. By the spring of 2007, the proportion of KidsCare applications processed in a timely manner had increased to 91 percent (Figure 3).

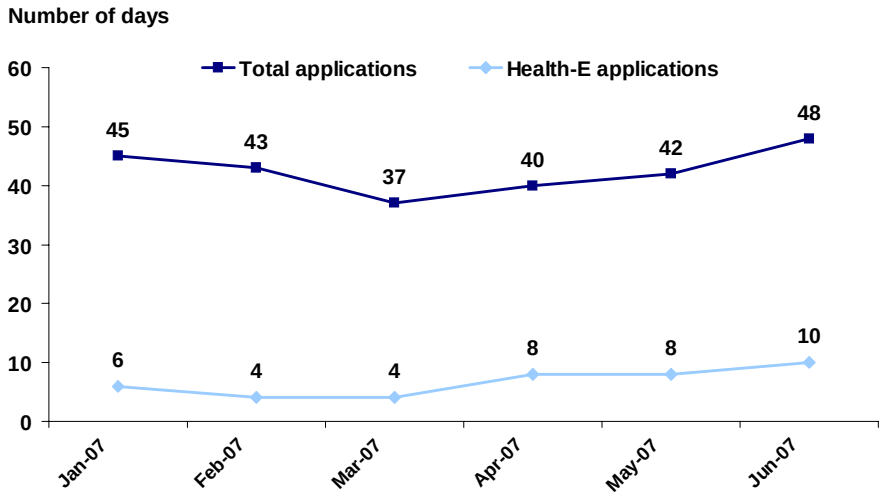
Figure 3. Processing Timeliness of Arizona KidsCare Applications
May 2006–August 2007



Note: Application processing in Arizona's KidsCare program is considered timely if it is completed within 30 days.
Source: Arizona Health Care Cost Containment System, 2007.

The Virtual Office pilot project, for example, allows some KidsCare eligibility workers to work from their homes while using a secure electronic system. By providing more flexibility and autonomy for these workers, Virtual Office addresses one of the factors that state officials say contributes significantly to difficulties at enrollment and renewal: high staff turnover as workers leave for other jobs. Additional factors contributing to personnel-related problems at AHCCCS offices have been the difficulty of attracting workers and budget-imposed hiring freezes. Arizona is also experimenting with "Health-E" electronic applications, which have been shown to reduce the processing time for KidsCare applications (Figure 4).

Figure 4. Average Processing Times for Arizona KidsCare Regular and Health-E Applications
January 2007–June 2007



Source: Arizona Health Care Cost Containment System, 2007.

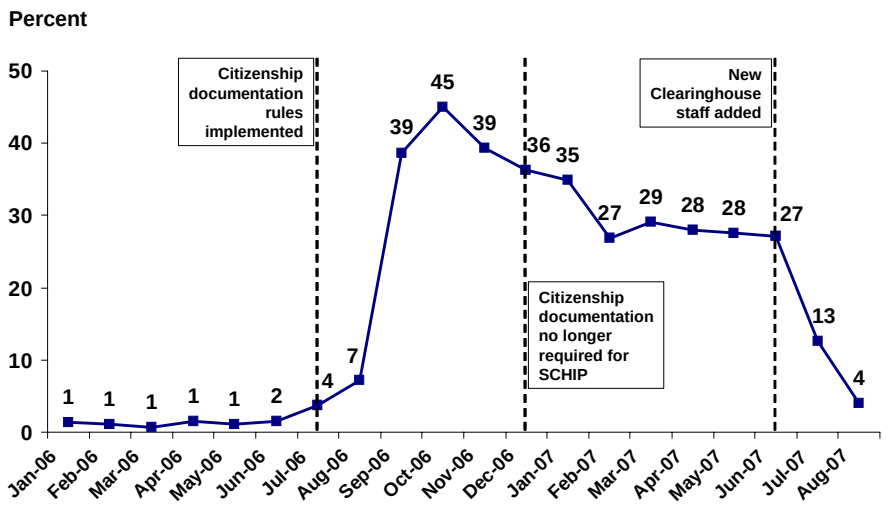
Kansas

Kansas HealthWave, which comprises separate Medicaid and SCHIP programs (each with different eligibility standards), saw an enrollment increase of about one percent in the six months before the citizenship documentation rules became effective in July 2006. In the six months afterward, however, enrollment declined by eight percent. During that same approximate period, the percent decrease in caseload was four times greater for non-Hispanic than for Hispanic children.[6] As a practical matter, Hispanic citizens appear to recognize that it is useful to have citizenship documents available. (Prior to the new rules, noncitizens already were subject to documentation requirements. Since 1986, all Medicaid applicants have been required to declare, under penalty of perjury, that they are U.S. citizens; noncitizens have been required to show documents to verify their status.[7])

One factor contributing to the initial enrollment decline in Kansas was the increase in pending applications. State officials reported that at the HealthWave Clearinghouse, which handles about 85 percent of children's Medicaid and SCHIP applications, the number of calls received more than doubled—from 23,110 in June 2006 (the month before citizenship documentation rules were implemented) to 49,042 four months later. For the first time, the state had to establish "backlog policies." The backlog eased somewhat when the state changed its initial policy of requiring citizenship documentation for SCHIP as well as Medicaid applicants. Later, the backlog was reduced considerably with the addition of new staff to process the applications and renewals. The Kansas Health Policy Authority used $1.2 million provided by the legislature to add 13

positions—eligibility counselors, customer-service staff, and document-verification staff—at the Clearinghouse (Figure 5).

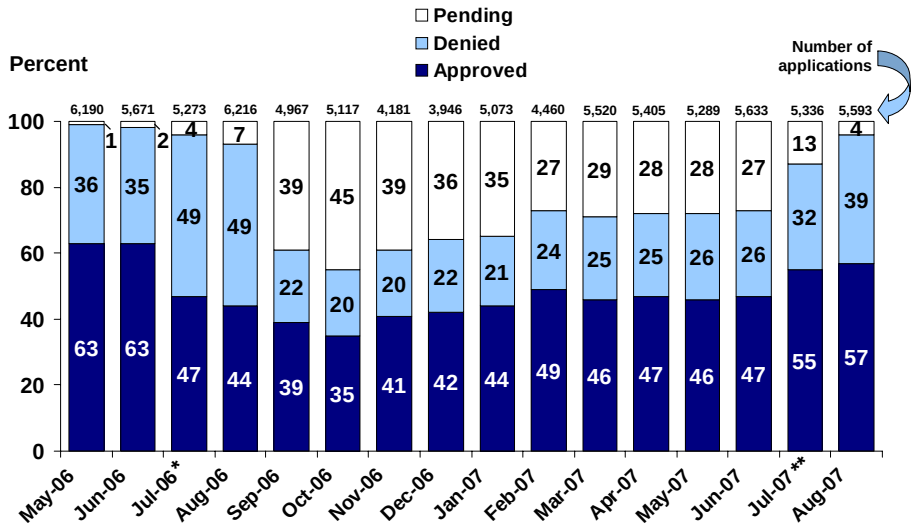
Figure 5. Applications Pending at the Family Medical Clearinghouse for Kansas HealthWave
January 2006–August 2007



Note: The Family Medical Clearinghouse handles about 85 percent of applications and renewals in the state.
Source: Kansas Health Policy Authority, 2007.

Decreases both in approval and denial rates occurred in Kansas as the proportion of pending applications increased. Approval rates were still below 60 percent in August 2007, even with improvements in processing applications; historically, these rates had been above 60 percent (Figure 6).

Figure 6. Status of Kansas HealthWave Applications
May 2006–August 2007



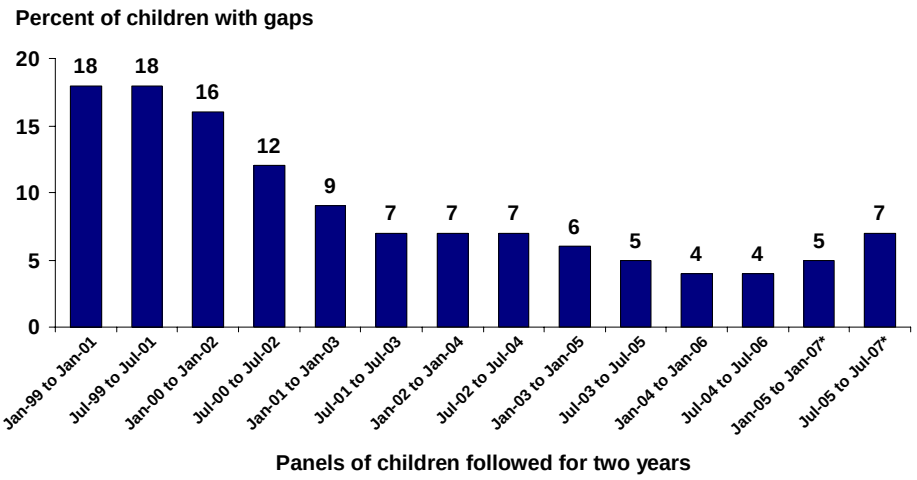
* Citizenship documentation rule implemented. ** Additional Clearinghouse staff added.
Source: Kansas Health Policy Authority, 2007.

Louisiana

The enrollment of children in Louisiana's Medicaid program declined in the six months before and after implementation of the citizenship documentation rules by 2.5 percent and 8.5 percent, respectively. Louisiana's situation is unique in that the displacement of so many enrollees following Hurricane Katrina in August 2005, and subsequent decisions about when to conduct renewals and when to terminate coverage for displaced individuals, had an impact on enrollment trends. Major post-hurricane outreach campaigns in communities also had an effect on enrollment.

Over the past several years, Louisiana has made stability of coverage for Medicaid enrollees a high priority, and the state has adopted a number of practices to increase enrollment and promote retention. Data from Louisiana show the state's progress over time in reducing coverage gaps for children and in maintaining stability through special renewal policies for New Orleans residents in the period following Hurricane Katrina. They also show the challenge posed by the citizenship documentation requirements (Figure 7).

Figure 7. Coverage Gaps for Panels of Children in Louisiana's Medicaid Program
January 1999–July 2007



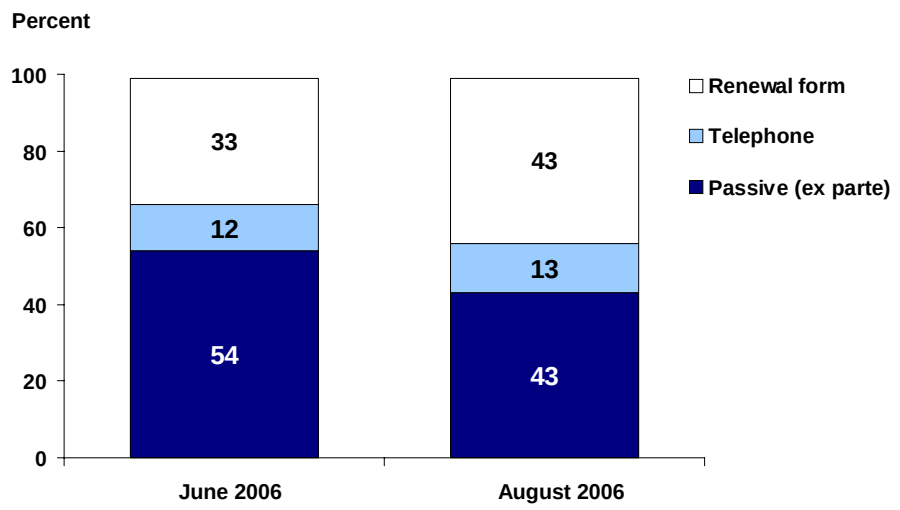
* These panels include the time, July 2006, when citizenship documentation rules were implemented.

Note: Each panel was followed for a two-year period. Panels included all children eligible in the beginning month who did not have coverage in the previous month and would not "age out" over the subsequent two years.

Source: Louisiana Department of Health and Hospitals, Division of Health Economics, 2007.

Individuals who leave public-insurance programs at renewal but remain eligible often reapply for benefits and re-enroll within a short period of time, a phenomenon known as "churning." Louisiana has spent years streamlining the Medicaid renewal process in an attempt to help eligible enrollees retain their coverage without a break. For example, the state conducts simpler telephone-based or "ex parte" renewals—which use existing and readily available information—instead of renewals that require enrollees to complete and submit forms. The latter are more time-consuming than other methods for eligibility workers and therefore more costly. Before the new policy went into effect, only about a third of renewals required the use of forms. After the implementation of the citizenship documentation rules, however, forms were involved in 43 percent of renewals (Figure 8).

Figure 8. Louisiana Medicaid Renewals for Children by Method
June 2006 and August 2006

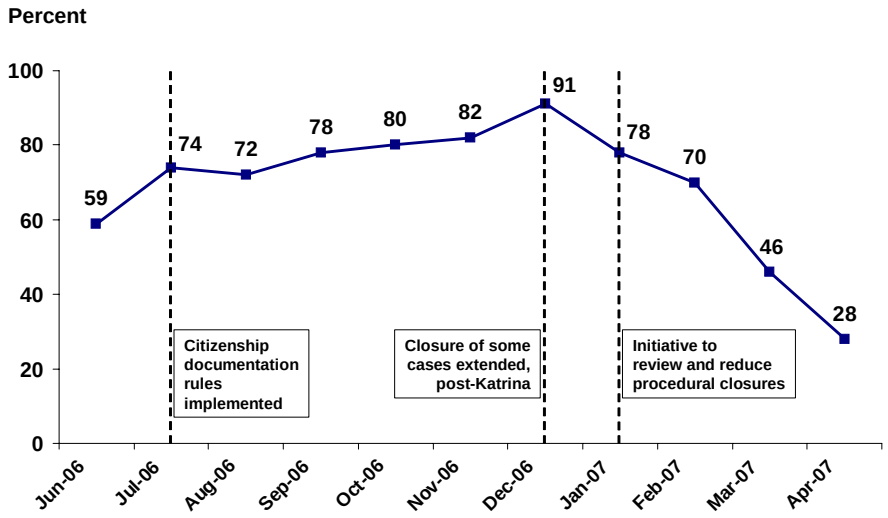


Note: Other methods account for less than 1 percent of renewals.
Source: Louisiana Department of Health and Hospitals, 2007.

Changes to simplify renewal had kept the closure rate at renewal close to 10 percent in 2005 and early in 2006, but the rate reached a high of 23 percent in October 2006. The increase likely reflected difficulties related to the citizenship documentation requirement and not to post-Katrina case closures, which did not occur until December.

Louisiana tracks the reasons for closure at renewal. Closures "for procedural reasons" are of particular interest because they represent individuals who likely are still eligible for benefits but have not completed the renewal process. The data show an increase, after the citizenship documentation rules were implemented, in the proportion of cases closed at renewal for procedural reasons and then a dramatic decrease in 2007. The decrease followed a state initiative to review procedural closure rates and provide training and technical assistance, particularly pertaining to the citizenship documentation rules, in areas where eligibility workers had high closure rates relative to their counterparts elsewhere (Figure 9).

Figure 9. Cases Closed at Renewal for Procedural Reasons Among Children in Louisiana's Medicaid Program
June 2006–April 2007



Source: Louisiana Department of Health and Hospitals, 2007.

Louisiana was better prepared than many other states when citizenship documentation rules came into play, as it already used an electronic case-record system. This made the rules somewhat easier to implement because eligibility workers had real-time access to vital information. Also, with a paperless system they were already scanning all documents at the point of application or renewal.

Louisiana's policy of conducting ex parte Medicaid renewals relies on electronic matches with other programs' records as well. Medicaid eligibility workers have access to information from the state Food Stamp, Temporary Assistance for Needy Families (TANF), and Child Support programs as well as from the state Department of Labor. Louisiana also pays a fee to use the "Work Number," a commercial wage-verification service.

The Louisiana system has other advantages:

- Eligibility workers can take laptop computers and remote scanners into the community to conduct enrollment clinics; this practice began, of necessity, after Hurricane Katrina. With a paperless system, there was less disruption with regard to Medicaid eligibility records than there would otherwise have been at the time.
- The integrated system allows regional and state officials to monitor eligibility operations across the state to determine where more or less training or technical assistance may be needed. As noted above, a state initiative in January 2007 reviewed procedural closings, which could be listed and sorted by eligibility worker, to determine where in the state additional training and technical

assistance could be most useful. The proportion of procedural closings at renewal decreased substantially after this initiative.

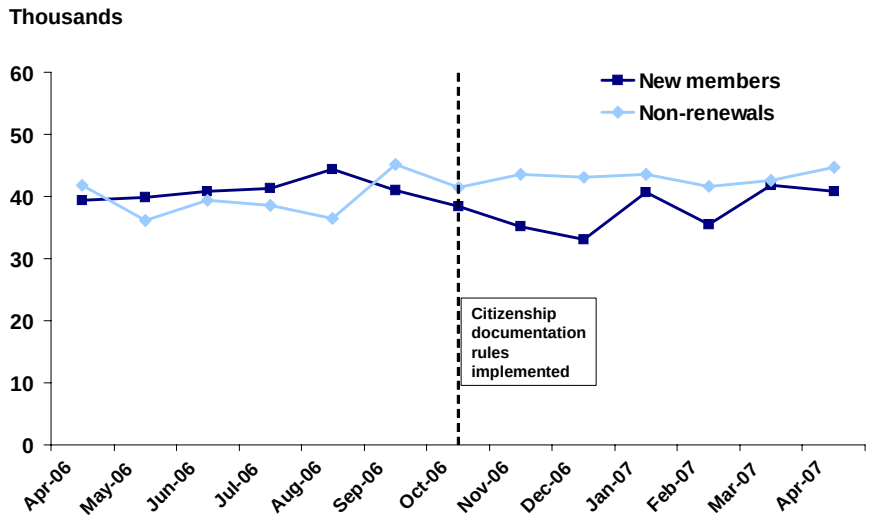
- State officials note that the electronic system has reduced administrative costs for salaries and benefits, file-room rental space, supplies (such as printed forms), and postage to mail records between offices.

Ohio

Enrollment in Ohio's Medicaid (Child and Family Coverage) program had increased by about one percent in the six months before the citizenship documentation rules were implemented (October 2006), but enrollment declined by 2.5 percent in the six months that followed. A reduction in the income-eligibility limits for parents (from 100 percent to 90 percent of the federal poverty level) may have led to enrollment decreases, and officials note that the major shift to managed care that occurred may have caused some confusion that contributed to enrollment declines as well.

Following implementation of the citizenship documentation rules, monthly enrollment reports for Ohio showed both a decrease in the number of new members approved for coverage and an increase in the number leaving the program at renewal (Figure 10). Meanwhile, the proportion of applications and renewals pending increased from 23 percent in October 2006 to 29 percent in January 2007 and 27 percent in April 2007.

Figure 10. Members Entering and Leaving the Ohio CFC Medicaid Program
April 2006–April 2007



Source: Ohio Department of Job and Family Services, 2007.

Officials note that the process was costly and, because no additional funds were appropriated, that implementation of the rules had to use resources intended for other

activities and initiatives. A detailed account of Ohio's tasks and estimated costs incurred in implementing the citizenship documentation rules in the state (Table 2) provides a sense of the strain on a state where administrative funds are already limited.

Table 2. Administrative Costs Associated with the First Year of Citizenship Documentation Rules in Ohio's CFC Medicaid Program

Task	Description	Cost
Plan for new policy	Meetings to convene state "Guiding Team"; develop procedures with Vital Records; establish new county-specific procedures.	$3,052[1]
Prepare materials	Training materials for state program staff and eligibility staff in counties; information materials to explain the new policy to applicants and enrollees; updates to existing publications; Web support; press releases.	$117,071[1]
Conduct or participate in training activities	Preparation for and participation in two-hour training sessions for eligibility specialists and supervisors in 88 counties.	$159,415[1]
Explain rule changes to others	State staff work with community groups, health plans, and providers to explain rules and implement them effectively; answer "hotline" or other sources of questions from the public; provide backup for particularly difficult cases.	$36,480[1]
Change management information systems	State staff reprogram the management information system, develop and generate new reports, provide ongoing support.	$538,858[1]
Monitor	Project-team meetings of state staff; extra monitoring of application timeliness, reason codes, pending applications, and other measures.	$101,368[1]
Spend extra time on applications and renewals	Eligibility specialists help applicants and enrollees understand the rules and obtain documents; "touch" pending applications extra times.	$3,927,621[2]
Pay for documents	Pay for birth certificates	$3,348,193[3]
Copy documents for case files	Scan, print, or copy documents for the files.	$202,921[4]
Return original documents	Mail original documents back to applicant or enrollee.	$125,811[5]
TOTAL		$8,563,949[6]

1. Estimate for personnel costs is based on the number of hours devoted to each task by each type of employee involved, including program, policy, eligibility, communications, compliance, management information, and technical-assistance staff at state offices as well as eligibility specialists and supervisors in counties.

2. Represents extra time for eligibility specialists, based on estimates from county officials and consistent with findings from the U.S. Government Accountability Office, *Medicaid: States Reported that Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens*, GAO-07-889, June 2007. Assumes workers spend 15 minutes extra per application or renewal and that 40 percent of the 2,029,028 applications and renewals processed in Ohio in the year following implementation of the citizenship documentation rules required extra assistance. Also assumes that eligibility supervisors spend 5 extra minutes for 5 percent of applications and renewals processed.

3. Assumes payment of $16.50 (cost of obtaining a birth certificate in Ohio) for 10 percent of 2,029,028 applications and renewals processed in Ohio in the year following implementation of the citizenship documentation rules. A 2006 survey indicates that 10.3 percent of U.S.-born adults age18 or older with incomes below $25,000 who have children report that they do not have a U.S. passport or U.S. birth certificate in their possession for at least one of their children. See: L. Ku, D.C. Ross, and M. Broaddus, *Survey Indicates the Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens* (Washington D.C.: Center on Budget and Policy Priorities, February 2006).

4. Assumes two copies, at five cents per copy, for the 2,029,028 applications and renewals processed in Ohio in the year following implementation of the citizenship documentation rules.

5. Assumes (based on estimates from county officials) that 20 percent of all applications and renewals processed in Ohio in the year following implementation of the citizenship documentation rules required the return of documents at 31 cents postage for return.

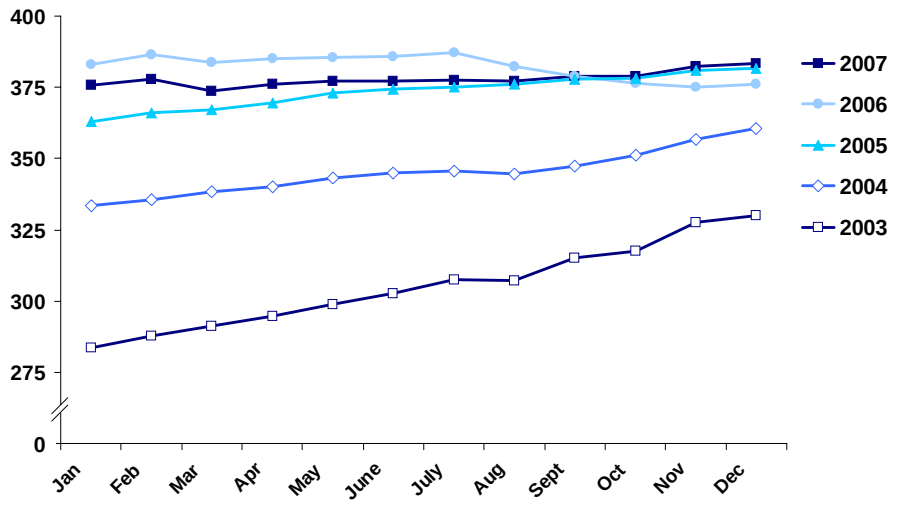
6. This is a conservative estimate, based primarily on personnel-cost information reported by state staff associated with Medicaid program operations. Costs related to tasks performed by staff in other state offices—the Office of Vital Statistics, for example—and costs related to tasks performed in county offices by staff other than eligibility specialists or supervisors are not included.

Source: Georgetown University's Health Policy Institute. Calculations are based on data from the Ohio Department of Job and Family Services and the Ohio Job and Family Services Directors' Association.

Virginia

Enrollment in Virginia's SCHIP and Medicaid programs, known as FAMIS (Family Access to Medical Insurance Security) and FAMIS Plus, respectively, held steady in the six months prior to the start of citizenship documentation, but enrollment decreased by 2.4 percent in the six months that followed. Figure 11 shows monthly enrollment trends for Virginia's Medicaid program over a five-year period. With the exception of 2006, when citizenship documentation rules were implemented, enrollment increased every year. The data also show that—again, with the exception of 2006—enrollment grows in the fall when outreach campaigns coincide with the start of school. It is interesting to note that, as in other states, Hispanics were less affected by the new rules than other population groups in Virginia. Medicaid enrollment for Hispanic children rose by 4 percent in the same six-month period that enrollment declined by 3.5 percent and 3.4 percent among black and white children, respectively.

Figure 11. Enrollment in Virginia's FAMIS Plus Medicaid Program, 2003–2007



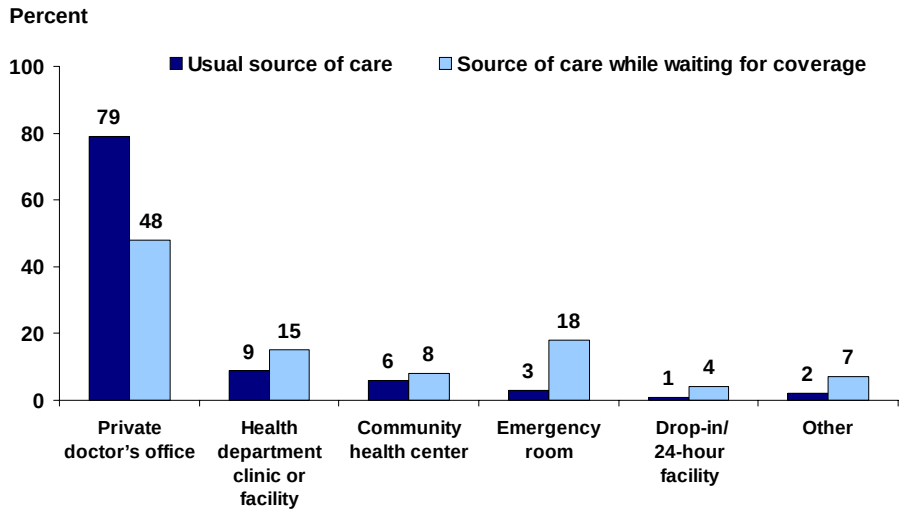
Source: Virginia Department of Medical Assistance Services, 2008.

Officials from Virginia report that more people had complicated questions about their Medicaid applications after implementation of the new rules. In focus groups, eligibility workers noted that they were taking more phone calls than usual and that the calls were lasting longer. Parents were asking where to get birth certificates, how long it would take to get them, and what they should do if their children needed health care services while they were waiting to be enrolled.[8] Virginia did not establish a special troubleshooting unit, but many local agencies ruled that eligibility workers could not close a case until a supervisor had reviewed it.

The more complex application and renewal processes that accompany the citizenship documentation requirements, and their effects on the timeliness and stability of coverage, have significant consequences for families. There is a period of uncertainty, while they are waiting for a coverage determination or during a coverage gap, when they may be reluctant to seek care, particularly preventive care. They may either pay for the care themselves or forego it altogether during that period.

This phenomenon was evident in the results of a telephone survey of Virginia families whose eligibility determinations for Medicaid were delayed or whose applications were still pending after implementation of the citizenship documentation rules.[9] Some 40 percent of parents whose children needed health care while waiting for coverage determinations reported that their children did not get all the care they needed. In addition, parents said that when they did seek care for their children they were more likely to go to emergency departments, drop-in facilities, and health centers or clinics—and less likely to use a private doctor's office—while waiting for coverage. These results suggest that continuity of care was compromised for a substantial portion of children waiting for coverage after the citizenship documentation rules were implemented. They also show that at least some children received care in places that were more costly than their usual care setting (Figure 12).

Figure 12. Sources of Care for Children in Virginia's Medicaid Program: Usual and While Waiting for Coverage



N = 359. Children who received some or all of the care they needed while waiting for coverage.

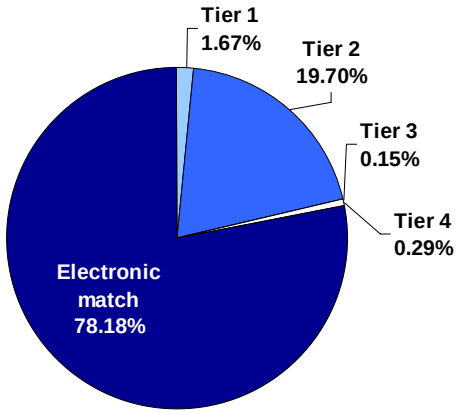
Source: *Unintended Consequences: The Impact of New Medicaid Citizenship Documentation Requirements on Virginia's Children,* Virginia Health Care Foundation, 2007.

Washington

In the six months preceding and following implementation of the citizenship documentation rules, Washington's public-coverage programs for children showed small enrollment declines—just under one percent before and two percent after. Several factors likely contributed to this relatively stable enrollment. One is that a total of almost $2.6 million was allocated—half of it state general funds and the other half federal Medicaid matching funds—to help implement the citizenship documentation rules through state fiscal year 2009. The administrative costs associated with setup and early operation of a Citizenship Central Unit, which helped current and potential program participants establish citizenship, totaled almost $1.3 million. The state then established a permanent unit of seven staff members to assist in verifying citizenship for new applicants.

Washington developed a special form that families lacking the necessary documents, but otherwise qualifying for benefits, can use to declare their citizenship. The case is then sent to the Central Unit, where state employees provide assistance. Also, in response to the citizenship documentation rules, the state conducted electronic "batch" matches four times in the first year to find birth certificates for applicants and enrollees. Batch matches accounted for more than three-quarters of the verifications. This approach not only promoted coverage stability but also saved a great deal of time for staff in the field and at the Central Unit (Figure 13). Eligibility workers continue to have access to information online for in-state birth certificates.

Figure 13. Methods to Verify Citizenship for Children in Washington's Public Insurance Programs
July 2006–June 2007



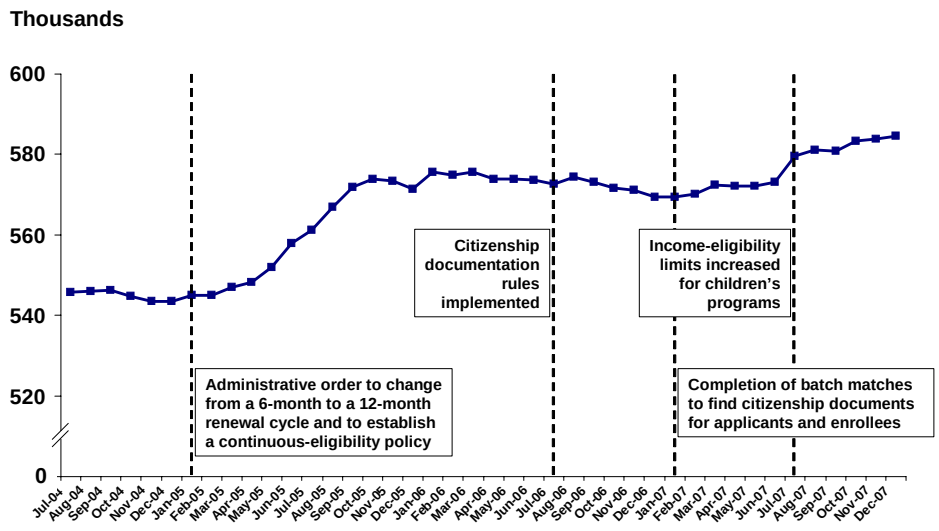
N = 449,265 verifications for applications and renewals.

Note: CMS has defined four levels, or tiers, of documents that can be used to prove citizenship, with preference given to the first two. Tier One is a U.S. passport, Certificate of Naturalization, or Certificate of U.S. Citizenship. Tier Two is a birth certificate or other specified record. Tier Three includes hospital, insurance, school, or religious records, and Tier Four specifies documents, as a last resort and subject to rigorous conditions, such as written affidavits. Documents to prove identity are also required for all but the first tier. Batch matches of birth certificates are considered the equivalent of Tier Two.

Source: Washington State Department of Social and Health Services, 2007.

As Figure 14 shows, changes in program policies are associated with changes in program enrollment. But likely as a result of measures that the state took with regard to implementing the citizenship documentation rules, their impact appears to be less dramatic than those of some other policy changes.

Figure 14. Children's Enrollment in Washington's Public Insurance Programs
July 2004–December 2007



Source: Washington State Department of Social and Health Services, 2007.

CONCLUSION

This study affirms findings from previous research efforts that simple enrollment and renewal processes promote more stable public-insurance coverage. By contrast, the new requirements for Medicaid applicants and participants to provide documentation of citizenship rendered the state enrollment and renewal processes more complex, administratively burdensome, and costly. The impact on applicants and participants differed among states, depending in part on their approach to implementation and their capacity (in terms of organization and technology) to cope with the rules. Some of the positive activity that occurred in response to the citizenship documentation rules can be replicated elsewhere and extended to promote more stable public coverage. Achieving coverage stability should be part of any larger discussion about expanding coverage, given that such stability increases the ranks of the insured, improves access to health services, and reduces the administrative costs of public programs.

ABOUT THIS STUDY

States were chosen for inclusion in this study based on a number of factors. The four states featured in previous research on coverage stability were approached first and asked to provide additional data.[10] Three of them—Louisiana, Virginia, and Washington—agreed to participate, but timing issues precluded the participation of the fourth, Rhode Island (which did not implement the citizenship documentation rules until January 2007). The other four states in the study—Alaska, Arizona, Kansas, and Ohio—were included because of their interest in the topic and willingness to participate and also because of the availability of relevant data. This group of seven states represented a variety of circumstances and policies affecting enrollment and coverage stability.

Initial interviews with state officials provided information about state circumstances and program policies. For the most part, the interviews were conducted by telephone, though researchers did make visits to Arizona and Ohio. Initially, states were asked to provide any relevant data on enrollment, individuals entering or leaving the program, applications received and processed, processing times for applications and renewals, renewal rates, and reasons for failure to enroll or renew. As anticipated, the amount and type of data delivered varied substantially among the states, but the researchers consulted with state officials when clarification was needed. Arizona, Kansas, and Louisiana officials also worked with the researchers to develop longitudinal databases that were then used to examine enrollment patterns for groups of enrollees; and officials in Alaska and Ohio provided detailed information on spending related to their implementation of the citizenship documentation rules.

State officials were asked to review all of the report's figures and text pertaining to the data they provided.

NOTES

[1] An interim final regulation was published in July 2006 and the final regulation in July 2007.

[2] "Strategies to Reduce Insurance Instability in Public Programs: Coping with New Medicaid Rules Regarding Citizenship Verification and Program Premiums," an invitational meeting (for state Medicaid directors) sponsored by The Commonwealth Fund. Washington D.C., Sept. 2006.

[3] Calculations of Georgetown University's Health Policy Institute, based on data provided by the Alaska Department of Health and Social Services.

[4] *Federal Register*, July 12, 2006 71(133):39220.

[5] U.S. Government Accountability Office, Medicaid Citizenship Documentation Requirement, GAO-07-889, June 2007.

[6] Data on ethnicity are self-reported.

[7] To qualify for the full range of Medicaid benefits, applicants must be citizens, nationals of the United States, or qualified aliens. Most legal permanent residents are ineligible for Medicaid or SCHIP during their first five years.

[8] Virginia Health Care Foundation, *Unintended Consequences: The Impact of New Medicaid Citizenship Documentation Requirements on Virginia's Children*, 2007.

[9] The survey sample was drawn from households that filed an application for Medicaid at the Central Processing Unit between July 2006 and January 2007. Interviews were conducted from February 22 through March 18, 2007. See: Virginia Health Care Foundation, note 8.

[10] L. Summer and C. Mann, *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies* (New York, The Commonwealth Fund, June 2006).

RELATED PUBLICATIONS

Publications listed below can be found on the Fund's Web site at www.commonwealthfund.org.

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Medicaid Re-Enrollment Policies and Children's Risk of Hospitalizations for Ambulatory Care Sensitive Conditions (October 2008). Andrew B. Bindman, Arpita Chattopadhyay, and Glenna M. Auerback, *Medical Care*, vol. 46, no. 10 (*In the Literature* summary).

Using What Works: Medicare, Medicaid, and the State Children's Health Insurance Program as a Base for Health Care Reform, Invited Testimony, House Committee on Energy and Commerce, Subcommittee on Health (September 18, 2008). Karen Davis and Cathy Schoen.

Losing Ground: How the Loss of Adequate Health Insurance Is Burdening Working Families: Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007 (August 2008). Sara R. Collins, Jennifer L. Kriss, Michelle M. Doty, and Sheila D. Rustgi.

Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies (June 2006). Laura Summer and Cindy Mann.