Issue Brief | February 2007

Sheila Hoag, *researcher*, Mathematica Policy Research, Inc.

Assessing the Impact of *Covering Kids & Families*
A national program of the Robert Wood Johnson Foundation

Deficit Reduction Act Citizenship Requirements through the Eyes of *Covering Kids & Families* Grantees

BACKGROUND

The Deficit Reduction Act (DRA) of 2005 (P.L. 109-171) attempted to reduce the federal budget deficit by implementing changes in a wide range of federal programs, including Medicaid. Among other changes to the Medicaid program, the DRA requires that all Medicaid recipients and future applicants prove their citizenship and identity, effective July 1, 2006, or at first subsequent redetermination (Centers for Medicare & Medicaid Services [CMS] 2006a). Most states had less than five months to develop and implement procedures for complying with DRA citizenship documentation requirements.[1,2] Federal guidance was issued just three weeks before the law took effect, and the guidance was stringent about what documents would be acceptable, although they were silent on the implications of noncompliance. Thus, states that had developed procedures prior to the guidance may have had to revise them to meet the federally established criteria.[3]

In July 2006, we interviewed 31 state *Covering Kids & Families* (CKF) grantees to understand how states were implementing DRA citizenship requirements in Medicaid.[4,5] This issue brief summarizes key findings from these interviews.

EXECUTIVE SUMMARY

In July 2006, researchers asked CKF grantees in 31 states how states were implementing DRA citizenship requirements in Medicaid. Due to belated federal guidance to states, five CKF grantees said that their states did not implement the citizenship requirements on time, and only 22 CKF grantees said their states had issued procedures on time to address the new requirements. CKF grantees identified problems with the new requirements, such as SCHIP applicants having to meet citizenship requirements in states using joint applications. Grantees also voiced fears that the DRA documentation requirements might result in a drop in Medicaid and SCHIP enrollment, an increase in the number of people who are uninsured, higher costs, and a reversal of many gains in simplification and coordination in Medicaid and SCHIP that CKF grantees helped achieve.

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MATHEMATICA Policy Research, Inc.

This issue brief was written by Mathematica Policy Research, Inc. Support for this publication was provided by the Robert Wood Johnson Foundation in Princeton, New Jersey.

KEY FINDINGS

Most state CKF grantees said that before the DRA, people did not have to provide proof of identity or citizenship to qualify for Medicaid.

Grantees verified that the DRA introduced new documentation requirements in most states: before July 1, 2006, for Medicaid, 24 of the 31 states did not require proof either of citizenship or of identity.[6] According to CKF grantees, prior to the DRA, for Medicaid, two states required proof of citizenship and identity; one proof only of identity; and two proof only of citizenship.[7] Two grantees were uncertain whether their state required proof of citizenship or identity for Medicaid applicants, although other sources indicate that the requirements were probably new in these two states.[8]

Five states reportedly delayed implementation of the DRA citizenship requirements because of confusion caused by belated federal guidance.

As of July 1, 2006, 26 of the 31 CKF grantees reported that their states had implemented the requirements for DRA citizenship documentation.[9] The other five grantees reported that their states had not done so. Of these five, three reported their state was delaying implementation until August 2006; one reported that their state was delaying it until September 2006; and one said their state had reported that it did not know when it would implement the new requirements (this state later announced that it would do so effective September 1, 2006).[10] In all five states, grantees said their states delayed implementation because: (1) initial federal guidance on the DRA documentation requirements was not issued until June 9, 2006 (CMS 2006b); (2) CMS did not issue final regulations on citizenship guidelines until July 6, 2006 (CMS 2006c); and (3) the Interim Final Rule was not issued until July 12, 2006 (CMS 2006a).

Twenty-two of the 31 states had issued procedures to address DRA citizenship and identity requirements in Medicaid; nine states had no procedures in place as of July 1, 2006.

We asked CKF grantees whether their states had put procedures in place to implement the DRA citizenship requirements, such as issuing guidance to eligibility workers on what documentation would be accepted, whether documents had to be originals or copies, how long applicants would be given to produce documentation and what happened if applicants could not produce it. In nine states (including two of the five that delayed implementation of the requirements), operational procedures had not yet been established to guide eligibility workers (or eligible applicants and enrollees). The grantees attributed this to delayed federal guidance. For example, one grantee from a state that

implemented the DRA as of July 1 said that state officials were still working on the procedures; at the time of the interview, officials did not have enough federal guidance to issue final procedures. Another state that delayed implementation of the DRA until August issued procedures for eligibility workers in early July, then retracted them after a CKF grantee pointed out that, for a variety of reasons, they were unworkable. Another grantee from a state delaying implementation of the law until August 2006 said that state officials waited for the Interim Final Rule to be issued (it was issued July 12, 2006). This state then drafted procedures that were circulated for review in early August with the hope that the state could implement the documentation requirements by the end of the month.

In all 22 states that had issued procedures on DRA documentation requirements, guidance to eligibility workers consisted primarily of a list of the newly required documents.

Of the 22 CKF grantees reporting that their state had issued procedures, all said that their states had issued a list of the required documents to whomever in their state handled Medicaid applications and renewals (generally, state eligibility workers). Given how little time states had between receiving federal guidance and implementing the law–just 21 calendar days–most states could not do more than this by the July 1 deadline. Some grantees noted additional procedures already implemented in their states:

- Four states already had sent letters regarding DRA documentation requirements to beneficiaries renewing coverage.
- Two states planned to purchase birth certificates for applicants and people renewing; another state was seeking funds to help applicants purchase birth certificates.
- One state asked its local Medicaid offices to track and assess what types of documentation Medicaid applicants are able to provide.

Many grantees noted that, while their states had issued basic lists of acceptable documents, state officials still had not made decisions critical to procedures on the DRA requirements, such as how long an applicant or a person renewing would have to produce documentation, or whether a person had to bring documentation in to an office for review or could send it through the mail. Rather, states issued the minimum procedures needed to comply with the law as of July 1, which they could later revise as more federal clarification was issued and as they gained experience with the law.

State CKF grantees identified problems and concerns associated with DRA documentation requirements.

Although we did not ask grantees about the problems encountered since implementation of the DRA, many grantees described some they had witnessed, including:

- The DRA applies to Medicaid recipients, but many states use a single application for Medicaid and SCHIP. Thus, SCHIP applicants will be required to comply with the new Medicaid documentation requirements.
- Grantees in states with "county-based" Medicaid programs report that the DRA was being interpreted and implemented differently in different counties.
- Two grantees noted that the DRA eliminated telephone and mail applications and renewals: applicants are required now to apply in person in these states because of the documentation requirements.
- One state issued guidelines showing that picture identification for children would be required; when the grantee noted that few children would have such identification, the state retracted the guidelines to revise them.

Other grantees voiced fears about the effects that documentation requirements might have, including:

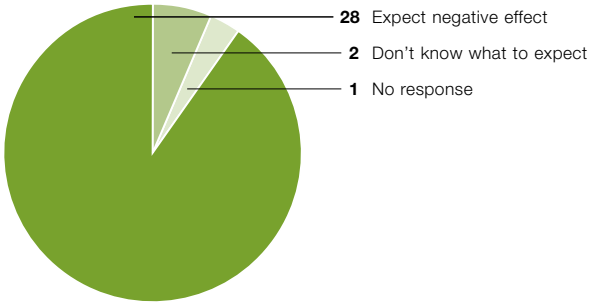
- Many grantees expressed concern that applicants would be sending in original documents (driver's license, birth certificate) to the state. Would states lose original documents? Would people feel confident sending documents in, or would they go without coverage?
- The cost of providing the proof could be expensive: birth certificates must be purchased from the state, and while a few states were trying to find funds to support their purchase, not all states planned to do so.
- One grantee did not believe the state Department of Health had the capacity to handle the expected increase in requests for birth certificates.
- In one state, people renewing Medicaid coverage have only 10 days to provide DRA documentation before being disenrolled. However, this state provides 90 days retroactive Medicaid coverage. Enrollees can "fall off" Medicaid, take 90 days to gather documents, and still have their care retroactively covered for the entire period. Thus, this grantee expects the law to create churning among Medicaid enrollees and thus increase costs to the state.

Eighteen of the 31 state CKF grantees said that their state had not publicized the new DRA documentation requirements to consumers. Among these 18, some noted that other groups–sometimes including the grantees themselves–had publicized the changes, but that their state agencies had not done so. Twelve grantees reported that their state publicized the documentation changes through Web sites, press releases, news coverage and public meetings.[11] We asked these 12 to assess the adequacy or sufficiency of the state's publicity efforts. Nine responded, with mixed findings. For example, three said it was too early to tell whether the state had done a good job; one said that the state had done a good job in getting information to community groups but not in getting it to consumers; one said the state had published information on a state website, which they judged as a "good start."

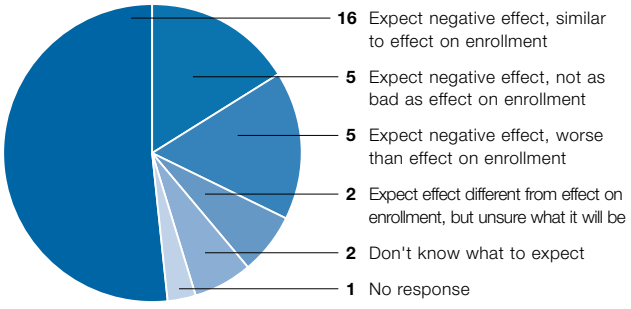
Most state CKF grantees expected the DRA to reduce Medicaid and SCHIP enrollment. Twenty-eight grantees expected the DRA to have a negative effect on new enrollment in Medicaid, as well as in SCHIP (*see Figure 1*).[12] Although the DRA documentation rules apply to Medicaid, the use of joint forms for Medicaid and SCHIP in some states, as well as screening of all applicants for

Figure 1: Expected Effects of DRA Documentation Requirements on New Enrollment and Retention in 31 States as Reported by CKF Grantees

Expected Effects of DRA Documentation Requirements on New Enrollment (Number of Grantees Reporting)



Expected Effects of DRA Documentation Requirements on Retention (Number of Grantees Reporting)



both programs in some states, means that SCHIP applicants in many states will be subject to the DRA documentation requirements.

Among the 28 grantees expecting the DRA to affect new enrollment negatively, 16 expect a similar negative effect on retention in the first year, as those Medicaid enrollees eligible under the old rules renew coverage for the first time under the new ones.[13] Five of the 28 grantees expect the effect on retention to be negative, but not as bad as on enrollment, while another five expect it to be worse (more negative) compared with the effect on enrollment. Two grantees thought the effect on retention might be different from the effect on new enrollment, but they did not explain whether they thought it would be better or worse for those renewing, compared with new enrollees.

Nearly all state CKF grantees are trying to improve implementation of the DRA documentation requirements.

All but one of the 31 grantees are trying to reduce barriers created by the DRA.[14] For example, 18 reported that their main task is serving as an "information clearinghouse," gathering data from the state on what the new documentation procedures and requirements will be and distributing it in some fashion (such as brochures, flyers, e-mail, community meetings) to local CKF grantees and other community and health organizations. Ten other grantees reported that their main task was working with the state, typically suggesting how to implement the law in ways that would be the least burdensome to clients. One of these grantees led DRA implementation in the state, ironing out implementation policies with state officials, initiating an "open your mail" media campaign about the DRA, establishing a hotline and a customer service guide on the DRA, helping the state establish a central location where all documentation could be sent, and working with community health centers to help enrollees and applicants respond to documentation requirements.

Most state CKF grantees believe the DRA is a barrier to achieving CKF's goals of enrolling and keeping people enrolled in Medicaid and SCHIP. However, only a few grantees view the DRA as the greatest barrier they currently face or have faced over the four years of the CKF grant.

Just six grantees named the DRA as the greatest barrier they currently face to achieving CKF goals. Far more grantees named another environmental barrier (including policy changes other than those contained in the DRA, limited state funding or Medicaid bureaucracy) as the greatest barrier they currently face (20 grantees). Only two grantees said the DRA was the greatest barrier to achieving CKF goals they had faced over the life of the grant, whereas the chief response (14 grantees) was that another environmental barrier (but not the DRA) was the greatest barrier they had faced over the life of the grant.

IMPLICATIONS

Our interviews with CKF grantees in the first month that DRA documentation requirements were in effect indicate that the short-term result was confusion among state officials and advocates (and likely among enrollees as well) about what the law required. This was largely because federal guidance was not provided until just 21 days before the law was to be implemented. Most state CKF grantees we interviewed responded to the confusion immediately: for example, they used their state Medicaid policy contacts to try to help shape DRA documentation procedures in their states, or they helped to interpret and disseminate state-issued procedures to a larger advocacy and community audience. Still, the confusion led some states to delay implementation of the law; in other states, the law was implemented, but without guidance as to how or what Medicaid workers or Medicaid applicants/recipients should do.

It is too early to determine whether there will be long-term implications of the DRA documentation requirements, although grantees described potentially serious consequences, including lower Medicaid and SCHIP enrollment, more people without insurance, increased churning and higher costs. CKF grantees voiced their concerns that the law will be a barrier to new enrollment and to retention of existing enrollees. They are also concerned about what the DRA documentation requirements will do to the gains in simplification and coordination that grantees helped achieve. For example, in many states, CKF grantees helped secure mail-in and telephone applications and telephone renewals, but the DRA documentation requirements may effectively eliminate these options (because of the risk of sending original documents through the mail). Many CKF grantees worked to create a joint Medicaid/SCHIP application; but this may mean that all SCHIP applicants will now be required to submit all the documentation required of Medicaid applicants.

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Appendix: Methodology

In July 2006, staff from Mathematica Policy Research, Inc., interviewed 34 *Covering Kids & Families* (CKF) state grantee project directors and/or project coordinators by telephone.[15] We included in the interviews those grantees whose CKF grant closed April 30, 2006, or later.[16] Interviewees were from the following states:

Alabama	Indiana	New York
Alaska	Iowa	North Carolina
Arizona	Louisiana	North Dakota
California	Maryland	Ohio
Colorado	Michigan	Oregon
Delaware	Minnesota	Rhode Island
District of Columbia	Mississippi	Utah
Florida	Missouri	Virginia
Georgia	Nebraska	Wisconsin
Hawaii	Nevada	Wyoming
Idaho	New Hampshire	
Illinois	New Jersey	

Three of the grantees said they did not know much about the DRA documentation requirements or how they were being implemented in their state. We excluded these three from our analysis of questions on the DRA citizenship documentation requirements, which left 31 grantees in the analysis.

The questions they were asked about the citizenship and documentation requirements of the Deficit Reduction Act include:

- Prior to the Deficit Reduction Act requirements, did your state already require proof of identity and citizenship for Medicaid or SCHIP eligibility for any populations?
- Has your state put procedures in place to deal with the DRA citizenship requirements?
- What are the new procedures?
- As the CKF grantee, are you working on this barrier to enrollment and renewal?
- If so, what are you doing?
- What effect are you expecting the DRA citizenship documentation requirements to have on new enrollment?
- Are you expecting a similar or different effect on retention in your state?

- What effect are you expecting on retention?
- Has the state made any efforts to publicize these forthcoming documentation changes?
- What is your assessment of the adequacy or sufficiency of these publicity efforts?
- What is the biggest barrier to achieving CKF goals that you are currently facing?
- Now I want to ask you to think back about barriers you faced over the life of the CKF grant. Thinking back, what was the biggest barrier you faced in trying to achieve CKF goals?

Endnotes

1. The DRA was signed February 8, 2006. According to CMS (2006b), at least three states already required proof of citizenship.
2. The DRA also authorizes optional changes to Medicaid which give states greater flexibility, such as introducing premiums, cost-sharing, and changes to the benefit package.
3. The law does not specify penalties for non-compliance with the citizenship documentation requirements; presumably, CMS could withhold a state's federal Medicaid matching funds until the state complied.
4. The Appendix describes how the states were selected for the study and lists the questions we asked grantees. Grantees were promised anonymity, thus no states are mentioned by name in this brief.
5. CKF state grantees work on Medicaid and SCHIP outreach, simplification and coordination, often collaborating closely with state policy officials.
6. Among these 24 states, one already required proof of citizenship for SCHIP, while another already required proof of citizenship and identity for SCHIP.
7. The two states that already required proof of citizenship and identity for Medicaid, as well as the one state that already required proof of identity for Medicaid, also did so for SCHIP applicants.
8. CMS does not list these two states as requiring such documentation prior to July 1, 2006 (see CMS 2006b), nor does another report describing states that required proof of citizenship prior to the DRA (see Boozang et al. 2006).
9. One of the 26 grantees implemented the DRA as of July 1, 2006, for new Medicaid applicants but delayed implementation of its documentation requirements for those renewing coverage until August 1, 2006.
10. According to officials at one of the states that delayed implementation, there was no penalty for this delay. In fact, they said that federal officials told state Medicaid directors (after July 1) that they recognized implementation might be delayed beyond July 1, since CMS guidance was issued so late, although this is not stated in writing in any of the State Medicaid Directors letters published on the CMS Web site.

11. Among the 31 grantees, one did not know whether the state had made efforts to publicize the DRA documentation requirements. However, this grantee noted that her state had required proof of citizenship for Medicaid prior to the DRA, so publicity about the law might be a moot point in her state.

12. Two of the 31 grantees were not sure what would happen to enrollment; one grantee did not answer the question.

13. A Medicaid applicant or recipient needs to provide proof only once, not each time coverage is renewed, unless there is a gap of more than three years between the last period of eligibility and a subsequent new application for Medicaid, or if other evidence arises raising questions about a person's citizenship (CMS 2006a).

14. The one grantee not working on the issue was located in a state SCHIP agency. Because of boundary issues between Medicaid and SCHIP, the grantee could not advocate in the state on Medicaid issues. However, the grantee was encouraging the CKF coalition to pursue these issues with the Medicaid agency.

15. One grantee was located within a state agency where state rules prohibited the grantee from participating in a telephone interview. This grantee completed a written questionnaire.

16. Most of the questions in the interview guide related not to the DRA, but to the overall CKF experience. Given concerns that grantees that closed more than two months prior to the July interviews might not be able to recall certain issues covered in the interview guide, those closing before April 30, 2006, were not included. This eliminated 12 CKF state grantees from the interviews.

This brief is part of the *Covering Kids & Families* evaluation. For more information on this evaluation series, please visit *www.rwjf.org/special/ckfeval*.

A Commitment to Evaluation

The Robert Wood Johnson Foundation is among the most significant funders of health and health care research in the United States. In fact, about one of every four grant dollars provided by RWJF supports research and evaluation. Findings from these initiatives highlight lessons learned from our investments and inform our future work. At the same time, our research efforts provide a useful knowledge base designed to assist our colleagues in health policy fields. We believe that developing and disseminating focused research and evaluation results will lead to sound, new solutions to the complex problems that affect the health and health care of all Americans.

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Route One and College Road East
P.O. Box 2316
Princeton, New Jersey 08543-2316
www.rwjf.org