

Policy Brief

An Initial Assessment of the Effects of Medicaid Documentation Requirements on Health Centers and Their Patients

Peter Shin, PhD, MPH, Assistant Research Professor
Brad Finnegan, Research Assistant
Lauren Hughes, Research Assistant
Sara Rosenbaum, JD, Hirsh Professor and Chair

The George Washington University
School of Public Health and Health Services
Department of Health Policy

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About the Geiger Gibson Program in Community Health Policy and the RCHN Foundation

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

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

Executive Summary

This policy brief presents the initial results from a project whose purpose is to assess the impact on health centers and their patients of recent federal Medicaid changes contained in the Deficit Reduction Act of 2006 (DRA), which require applicants and recipients to document both their citizenship or legal U.S. residence and proof of their personal identity. In 2005, the nation's 952 federally funded health centers furnished health care in over 5000 service sites to more than 14 million persons, including 5 million Medicaid beneficiaries.

Medicaid accounts for 37 percent of all health center operating revenues, thereby making changes in Medicaid policy particularly important to the long-term stability and strength of the health centers program. In addition to providing comprehensive primary health care, health centers offer Medicaid enrollment assistance at virtually all service sites, and state Medicaid agencies must ensure outstationed enrollment assistance at health centers.

Federal regulations implementing the DRA use strict proof requirement and specify that only original or certified copies of documents can be used to prove citizenship and identity. A recent federal clarification relaxes these rules for newborns but only those whose mothers are already enrolled in Medicaid at the time of their birth, thereby excluding infants whose mothers have applied for Medicaid but are not yet enrolled.

Initial results from a random nationwide survey of 300 health centers reveal that:

- Documentation requirements have caused a nationwide disruption in coverage for health center patients, with more than 90 percent of all health centers reporting enrollment difficulties for patients of all ages, including newborn children.
- More than 25 percent report a longer application process, 30 percent report a longer enrollment process, 28 percent report that applications lack appropriate documentation, over 10 percent report that patients must pay to obtain documents, and one in seven report delays in securing documents. Forty three percent of health centers reported that their patients had at least one of these problems. Among health centers experiencing Medicaid patient enrollment declines, two thirds identified implementation of documentation requirements in their communities as an underlying factor
- More than one third report that they have had to increase the amount of staff time available to assist patients with their applications, ranging from a few hours per week to 40 hours per week, or the equivalent of one additional staff member.
- 45 percent report that enrollment and application disruption and delay have affected their ability to arrange for specialty care; 38 percent report difficulties in securing health care access for new patients; 28 percent report difficulties in pre-arranging hospital inpatient deliveries for pregnant women, and 24 percent report difficulties in securing supplies and equipment. Pregnant women and children were no exception.

- Even when only children and pregnant women are considered, health centers reported similar effects from application delays and disruptions.

We estimate conservatively that the immediate impact of the documentation requirements will be to eliminate Medicaid coverage for between 2.2 and 6.7 percent of all Medicaid enrolled pediatric and adult patients. This translates into between 105,100 and 319,500 Medicaid patients, including up to 212,400 children and 107,100 adults.

	Estimated Immediate Loss of Medicaid Coverage Among Health Center Patients		Total Health Center Patients with Medicaid
	Low	High	
Children	69,900	212,400	2.9 million
Adults	35,200	107,100	1.9 million
Total	105,100	319,500	4.8 million

In general, these estimates should be interpreted with caution because they are so conservative. But these estimates provide insight into the initial magnitude of the impact. Indeed, health centers' own reported experiences suggest that ultimately the effects will be far greater. Furthermore, this early estimate does not include estimates of patients who can be expected to experience delays and barriers to future Medicaid enrollment.

This immediate loss of Medicaid coverage for current health center patients will translate into immediate financial losses of between \$28 and \$85 million in Medicaid revenues. These revenues represent:

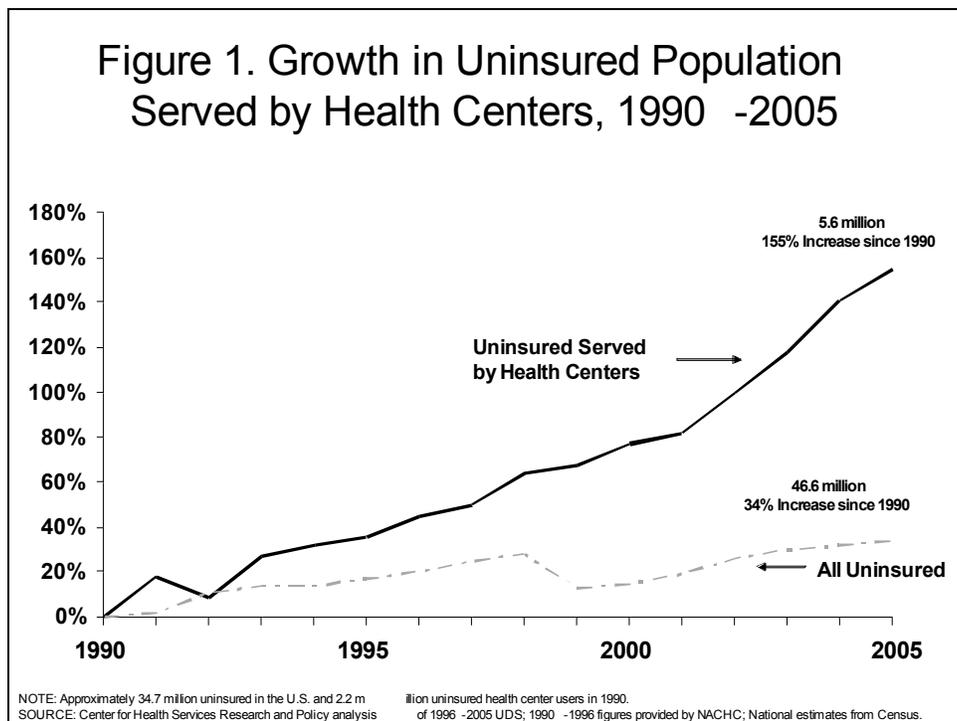
- Services to between 55,000 and 166,000 uninsured patients.
- Staffing reductions of 27 to 83 physicians, 21 to 66 dental professionals, 6 to 18 pharmacists, 11 to 33 mental health professionals, and 46 to 140 nurses and physician assistants.
- An average of one percent loss of all health center operating revenues and the entire operating surplus reported by health centers in 2005, which is crucial in planning for unanticipated emergencies.
- The establishment of 43 to 131 "new start" health centers in the nation's poorest counties.

Introduction

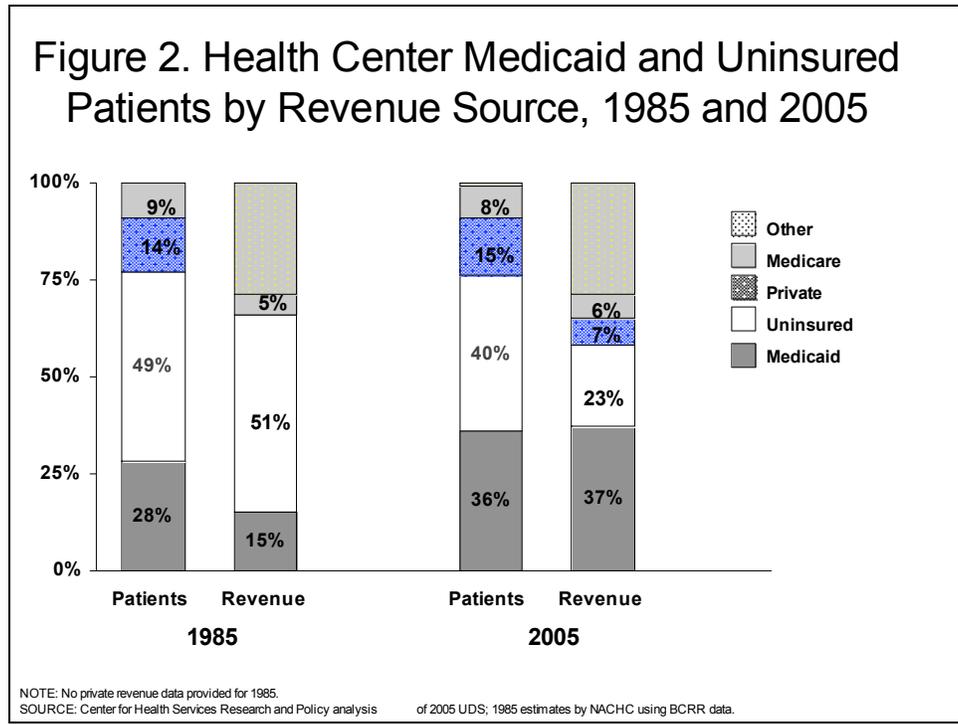
This policy brief presents the initial effects of recent federal Medicaid reforms on health centers and their patients. Specifically, this report examines the impact of changes in federal Medicaid policy, contained in the Deficit Reduction Act of 2006 (DRA), which requires applicants and recipients to document both their citizenship or legal U.S. residence and proof of their personal identity.

Health centers are the nation's largest single source of primary health care for low income and medically underserved persons, including Medicaid beneficiaries. In 2005, 952 federally funded health centers operating in more than 5000 service sites provided health care to more than 14 million persons, including over five million Medicaid beneficiaries.

Health centers play an essential role in the health care system, both ensuring timely access to comprehensive primary health care and serving as a critical bridge to medically necessary specialty services. As the number of uninsured persons has risen nationally, the need for reduced cost services at health centers has correspondingly grown at an even more rapid pace. Figure 1 shows that the number of uninsured grew by 34 percent nationally between 1990 and 2005, while the number of uninsured persons served at health centers grew by 155 percent.



Medicaid represents the largest single source of health center financing. Figure 2 shows Medicaid made up 37 percent of health centers' operating funds in 2005, representing a 250 percent increase over 1985 levels, when far fewer persons were eligible for Medicaid. Moreover, in 1985, Medicaid's special requirements related to coverage of and payment for "federally qualified health center services" had not yet been enacted. Medicaid represents the largest single source of financial support for health center operations. This strong relationship among health centers, health center patients, and Medicaid means that major Medicaid policy changes, such as the documentation requirement, can be expected to significantly affect health centers.



Health centers are important to their patients not only because of the comprehensive primary health care they furnish but also because they play a major role in helping patients secure Medicaid coverage and other patient and family support services. As part of these patient assistance activities (known as "enabling services") health centers offer help in obtaining and completing Medicaid application forms and securing necessary documents and supporting information. In 2005, all health center grantees offered enabling services that were available at nearly all health center service sites.

Consistent with health centers' enabling service obligations, federal Medicaid policy requires that state programs offer "outstationed enrollment assistance" through federally qualified health centers and certain other health care providers.¹ Federal regulations implementing this outstationing requirement specify that states ensure that all "high volume" health centers can receive and initially process applications. Initial processing consists of help in completing

applications and gathering documentation. At their choosing, states can permit the entire application process, including verification and final enrollment, to occur at health center sites. A study conducted by the National Association of Community Health Centers in 2005 found that three states - Connecticut, Oregon, and Utah - reported full assistance available in all high volume health center service sites. The study also found that health centers uniformly offered services regardless of whether enrollment assistance was financed by the state or the health center.² Thus, patients of health centers can obtain enrollment assistance that might not be available at other health care service sites.

The DRA Medicaid Documentation Requirements

Eligibility for full Medicaid benefits (as opposed to coverage for emergency care only) requires that individuals who meet other program requirements be citizens or nationals of the U.S. or legal immigrants who have lived in the U.S. for over five years.³ Undocumented persons and legal residents who have not yet met the qualified residency test can receive emergency care coverage.⁴ One recent study suggests that this coverage consists almost entirely of payments for childbirth and complications of pregnancy, as well as inpatient hospital care for severe complications arising from underlying chronic conditions.⁵

Since 1986, federal law has required that when individuals apply for full Medicaid coverage, states must obtain a written declaration from applicants, under penalty of perjury, regarding their legal status.⁶ Applicants who declare that they are not citizens have also had to show satisfactory immigration documents⁷ that are verified with the U.S. Citizenship and Immigration Services Bureau of the Department of Homeland Security.⁸

In 2006, as part of the Deficit Reduction Act (DRA),⁹ Congress revised the Medicaid statute to extend documentation requirements to applicants and current recipients who declare that they are citizens. All new applicants and recipients, whether they are citizens, U.S. nationals, or qualified aliens, must document their identity.

The documentation requirements exempt Medicare beneficiaries, persons receiving Social Security benefits on the basis of age or disability, and persons receiving Supplemental Security Income (SSI) benefits. Further legislative amendments enacted at the end of 2006 as part of the Tax Relief and Health Care Act¹⁰ exempt children receiving child welfare assistance, special needs foster care, or adoption assistance under Titles IV-B or IV-E of the Social Security Act.¹¹

The Centers for Medicare and Medicaid Services (CMS), the federal agency that administers Medicaid, published interim final rules in July 2006 that implemented the DRA amendments.¹² The rules set the federal standards the agency will use in measuring the adequacy of documents presented, the permissible timelines for

presenting documents, and the applicant and recipient groups to whom documentation requirements apply. Documents must be originals or copies certified by the issuing agency.¹³ The interim rule also prohibits the granting of eligibility until satisfactory documents have been presented.¹⁴

While the new law requires states to provide “reasonable opportunity” and assistance in securing the “satisfactory documentary evidence of citizenship or nationality,” the interim rule leaves unclear what type of assistance must be furnished. The interim rule also does not clarify the relationship between documentation and separate federal regulations pertaining to outstationed assistance available at FQHCs – for example, whether the receipt and initial processing of applications at outstationed locations can or must include inspection of documents. Evidence to date suggests that states have implemented the documentation requirements in variable ways and that there is considerable variation in how states utilize outstationing as a means of assisting applicants and recipients.

The interim rule was modified by the legislative reforms enacted in late 2006, as well as by a CMS notice issued in March 2007. This notice clarified that newborn infants born to women receiving Medicaid coverage under any category, including emergency coverage, are to be deemed eligible for up to a year.¹⁵ The CMS notice contains two important caveats, however. First, it clarifies that, as with other recipients, newborns will be required to prove citizenship and identity at redetermination. Second, the CMS notice applies only to women who have applied and have been determined eligible for Medicaid at the time of their infants’ births.¹⁶ That is, infants born to women whose applications are pending at the time of birth would not be included in the CMS newborn eligibility clarification. Many women who seek coverage only for emergency delivery services may in fact apply for Medicaid only once hospitalized for the emergency itself.

An early analysis of the impact of the Medicaid documentation reforms estimated that approximately 10.3 percent of citizen children and 8.1 percent of citizen adults would experience delayed or interrupted coverage as a result of the new documentation standards.¹⁷ Anecdotal reports from health centers and state and regional health center primary care associations, as well as studies documenting early state experiences, have suggested that the effects of the requirements are beginning to be felt. For example, one early assessment of impact in Wisconsin found that 70 percent of those persons either losing or denied Medicaid coverage because of documentation requirements were citizens, with the most significant barrier being proof of identity.

States also have reported increased administrative costs associated with citizenship documentation. A March 2007 study conducted by the Center on Budget and Policy Priorities reported an increase in the number of states reporting “marked declines in Medicaid enrollment, particularly among low income children.”¹⁸ Seven states - Wisconsin, Kansas, Iowa, Louisiana, Virginia,

New Hampshire, and Ohio - all reported significant changes as a result of terminations, application backlogs and delays, and the additional complexities associated with administering the new documentation requirements.

A March 2007 newspaper story from Kansas reported that nearly 20,000 Kansans had lost Medicaid benefits, with health centers reporting delayed care as a result.¹⁹ One health center reported a 42 percent increase in the number of uninsured children treated in the six-month period prior to the story and a 68 percent jump in health care services furnished. This suggests that the loss of coverage might be encouraging newly-uninsured low income families, who had previously received coverage elsewhere, to rely on health centers for assistance.²⁰ Because such a high proportion of all health center patients fall into the non-exempt child and non-elderly adult groups, the effects of the documentation policy were anticipated to be significant, despite the presence of outstationing assistance that might mitigate but not entirely eliminate the effects of the new requirements.

Study Methodology

This study was undertaken by a special health center research collaborative that is part of the Geiger Gibson Program in Community Health Policy in the George Washington University School of Public Health and Health Services. Additional funding for this study also was provided by the Kaiser Commission on Medicaid and the Uninsured. Designed to assess the impact of the documentation requirements on health centers and their patients, the study consists of several components:

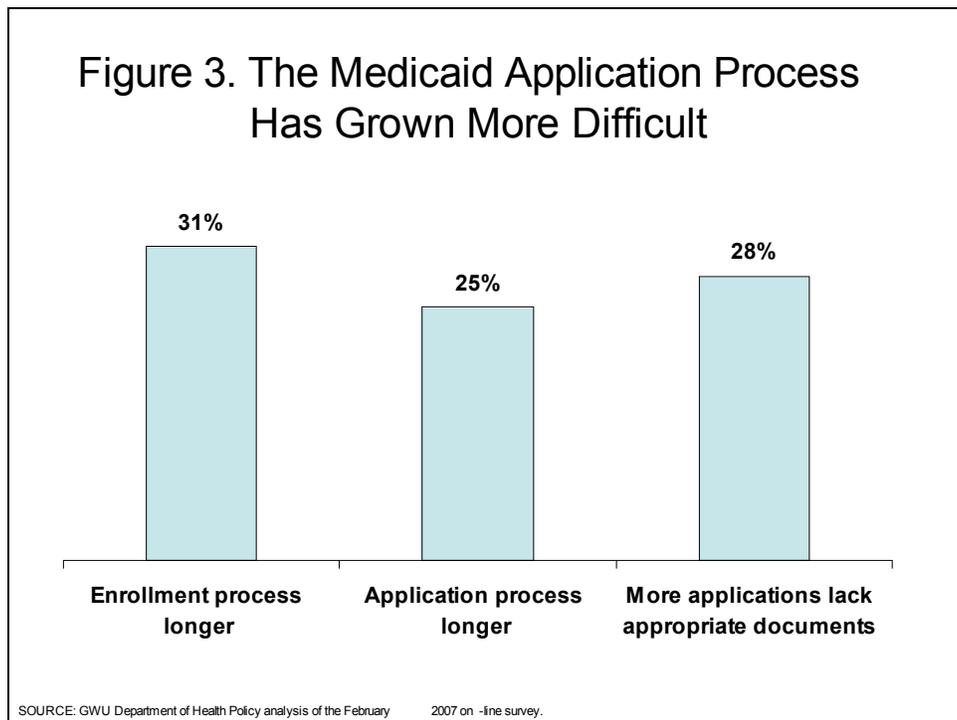
- Conducting a national survey of 300 randomly selected health centers in order to gauge early experience with implementation of the documentation requirements. A national survey of all health centers will be conducted at a later time to assess state specific impacts.
- Documentation impact estimates using available UDS data, as well as the results of earlier impact studies.

A more detailed methodology covering each element of this study can be found in the Appendix to this Policy Brief.

Study Findings

1. Health centers nationally report coverage delays and disruption as a result of implementation of the documentation requirements. Health centers also report measurable effects on their ability to provide appropriate health care.

Figure 3 indicates the ways in which health centers report that the application process has grown more difficult. Thirty one percent of health centers report that the enrollment process has grown longer, while 25 percent report that the application process has grown longer. Twenty-eight percent report that applications lack necessary documents.



In addition, Figure 4 shows that applicants are experiencing challenges related to securing documents: 11 percent of health centers indicate that applicants must pay to get documents, and 15 percent report that applicants have to wait two weeks or longer to obtain needed documents. Forty three percent of health centers report at least one problem with a longer application process or with documentation.

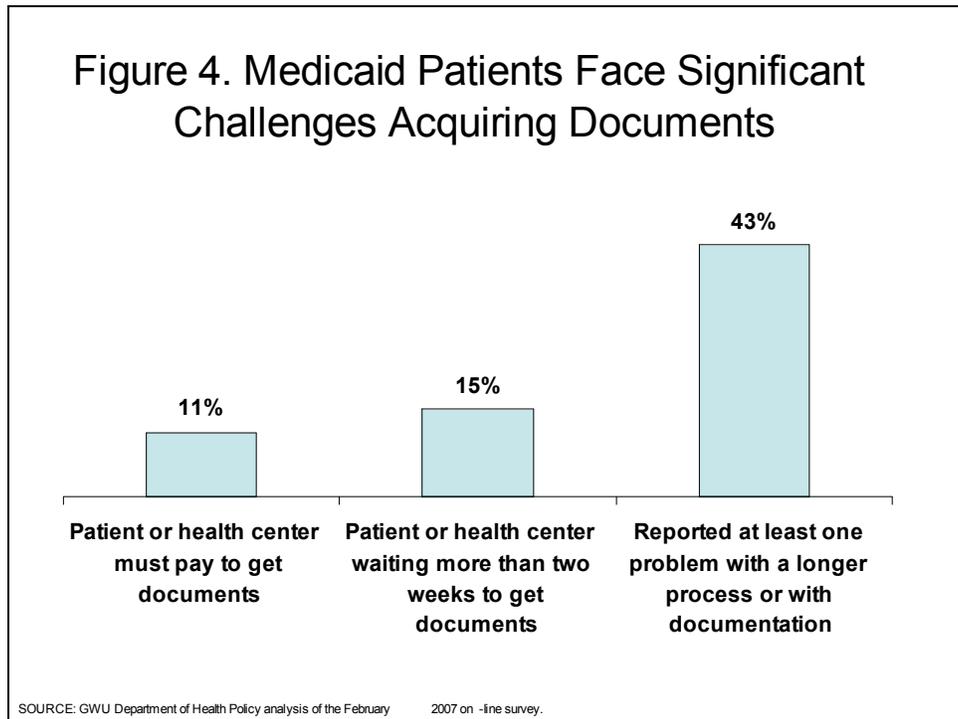
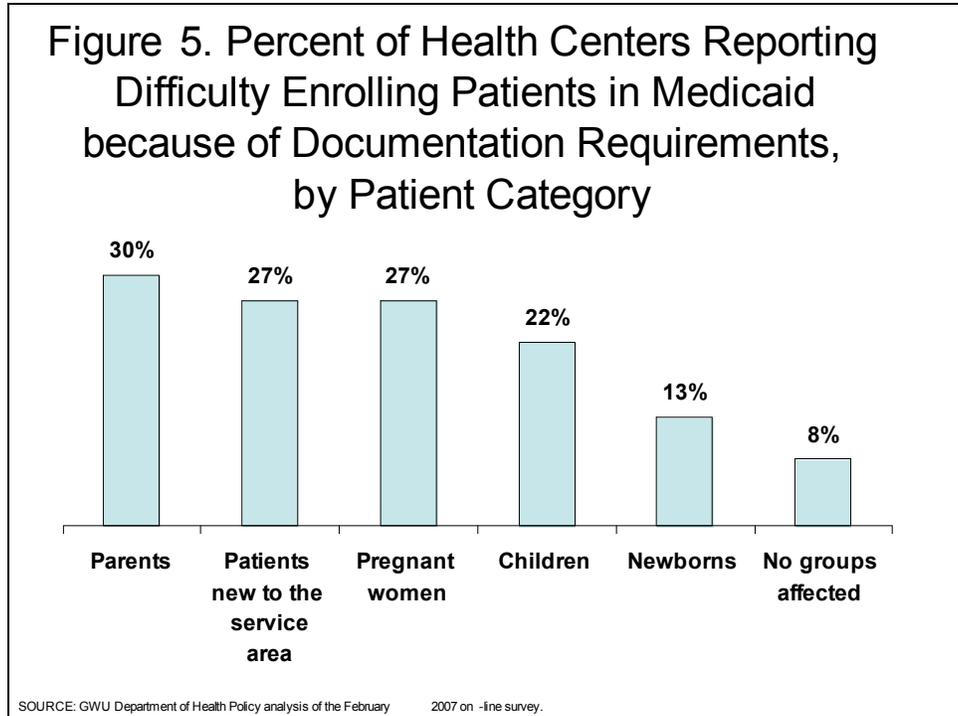
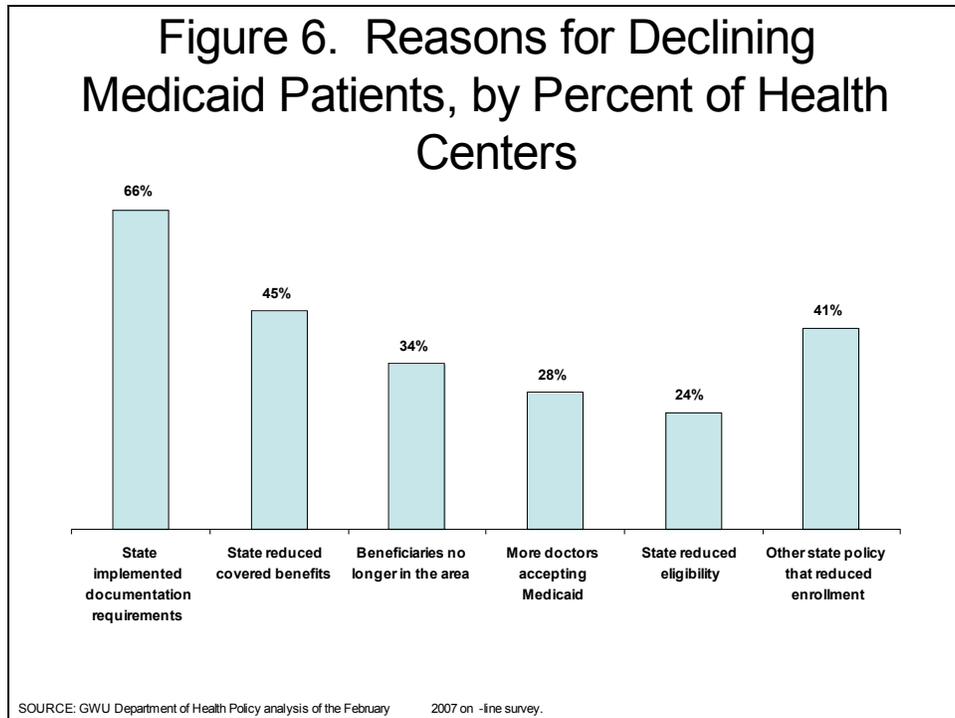


Figure 5 shows the extent to which health centers report that one or more patient groups are experiencing difficulties. More than 90 percent of all health centers report application difficulties affecting one or more patient groups. Thirty percent report that parents are experiencing difficulties; 27 report that new patients and pregnant women are experiencing problems, and 22 percent report difficulties among children. A significant proportion of health centers – 13 percent – report newborn problems. Only 8 percent of all health centers report that no patient groups are experiencing problems.

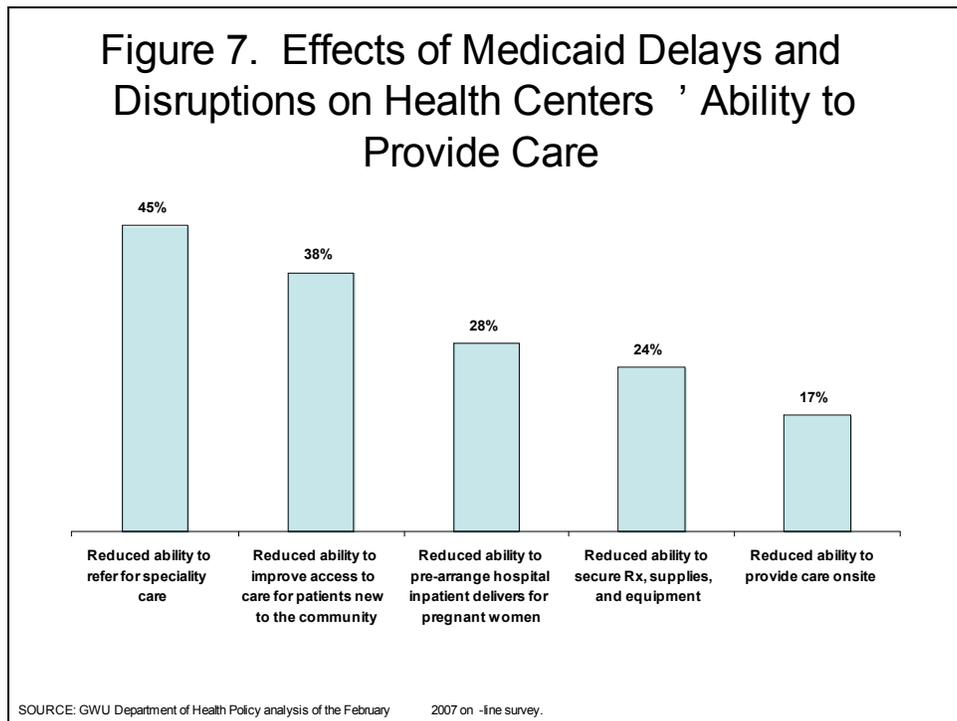


More than 20 percent of all health centers also reported an actual decrease in Medicaid patients, even as their uninsured patients continued to rise. A closer examination of the reasons for the decline in Medicaid users at these health centers shows that the new citizenship and identification requirements are emerging as the single most important cause. Figure 6 shows that 66 percent of health centers experiencing a Medicaid patient decline identified implementation of documentation requirements in their communities as an underlying factor, compared to 45 percent reporting reductions in eligibility or changes in patient mix.

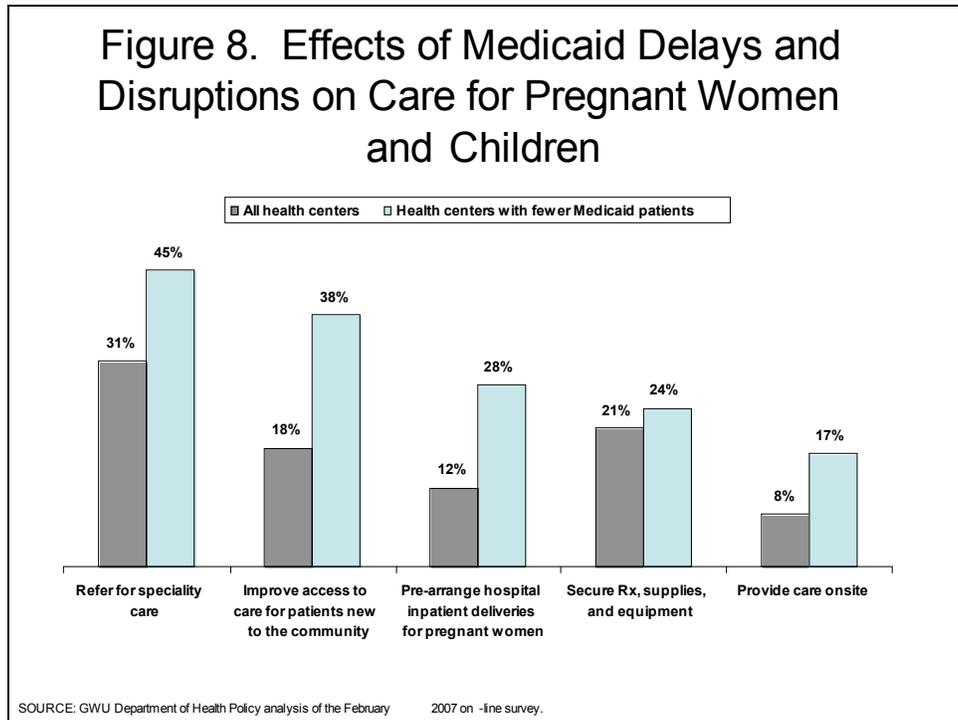


Even as Medicaid delays and disruptions grow and coverage itself is threatened, patients remain eligible for services at health centers on an uninsured basis, and respondents indicated that this is the case. More than 60 percent of all respondents indicated that they were furnishing health care to patients who had lost their Medicaid coverage and who required health care prior to reinstatement.

Medicaid's critical role in funding health centers and enabling them to provide or arrange for specialty and referral care means that coverage interruptions can be expected to translate into an impact on the accessibility and quality of care. Figure 7 shows that Medicaid interruptions appear to be having this type of impact, particularly where the interruptions have led to an outright coverage decline. Disruptions and delays in care were reported by health centers for all patients, with 45 percent of health centers reporting reduced ability in arranging for specialty care, 38 percent reporting difficulties in securing health care access for new patients, 28 percent reporting difficulties in pre-arranging hospital inpatient deliveries for pregnant women, and nearly one quarter reporting difficulties in securing supplies and equipment.



Pregnant women and children were no exception. Figure 8 shows that even when only children and pregnant women are considered, health centers reported similar effects. These effects were particularly evident for health centers experiencing a decline in Medicaid covered patients.



Community Impact Portraits of the Medicaid Documentation Requirement

New York State has required documentation of citizenship for Medicaid over the past three decades. As a result, many observers assumed that the federal Medicaid policy documentation reforms would have little impact. This has turned out not to be the case, according to staff of Community Health Care Network in New York City (CHNNY), which serves over 60,000 patients a year, and who reports significant declines in recertification rates among patients who are citizens, nationals, and qualified aliens. Adolescents seeking family planning services have been particularly affected. Prior to issuance of the federal regulations, the state had permitted minors to provide copies of necessary documents. Because the July 2006 federal rule requires either originals or certified copies, this previous state policy is no longer permissible. Teenagers continue to have access to family planning services but on an uninsured basis, since the change in law has prevented teens from keeping or acquiring Medicaid coverage. Catherine Abate, President and CEO of CHNNY, views the policy as contributing to an even greater growth of uninsured patients who depend on the clinic and views the situation as "woeful". Although it is early in the annual recertification process, clinic staff reported a 50 percent enrollment drop over several months in one of the managed care plans in which the health center participates.

* * *

Valley Wide Health Systems, Inc., which is located in southern Colorado and serves approximately 50,000 patients, reported a substantial backlog of applications awaiting documentation. As a result, patients are experiencing periods without coverage lasting weeks longer than the normal application process would otherwise have required. Because these patients have significant health care needs that must be met regardless of their insurance status, the health center has simply absorbed the costs. According to executive director Margarite Salazar, "We see a lot of Medicaid patients as we are the main game in town ... the cost has gone up because we've had to hold on to applications longer. Our cash flow is affected because we're not billing." Salazar notes that the requirements have increased the health center's administrative obligations at the same time that their cash flow has been affected. "The bottom line is that these requirements have caused an increase in administrative costs. Every time you [are helping patients with paperwork, you are taking] time away from patient care. And that's unfortunate."

2. A conservative estimate of the immediate impact of the documentation requirements on health center patients currently enrolled in Medicaid is that in the near term, up to 319,500 Medicaid-enrolled health center patients -- including up to 212,400 children and 107,100 adults -- will lose coverage.

In addition to the health center survey and interviews, we developed a *conservative* national estimate of the *near-term* impact of the Medicaid documentation requirements on Medicaid enrolled health center patients. Our estimate includes *only those patients who are currently enrolled*. Furthermore, we estimate that they will lose coverage only for a few months due to assistance from health centers in re-gaining coverage. Our estimates exclude newborns, even though health centers are reporting an impact on this population and even though the recent CMS policy may reduce, but certainly will not eliminate, the loss of coverage. We also exclude disabled and elderly Medicaid beneficiaries because they are exempt from the documentation requirements.

Table 1 illustrates the estimate range. It shows that the new requirements will eliminate coverage for up to 212,400 children and up to 107,100 adults nationwide. We estimate that the risk of coverage loss will affect between 2.2 and 6.7 percent of all Medicaid enrolled health center patients. These percentages translate into a national estimate of 105,100 to 319,500 Medicaid enrolled children and adults who receive health care through health centers and who risk the loss of coverage for some period of time.

	Table 1. Estimated Immediate Loss of Medicaid Coverage Among Health Center Patients		Total Health Center Patients with Medicaid
	Low	High	
Children	69,900	212,400	2.9 million
Adults	35,200	107,100	1.9 million
Total	105,100	319,500	4.8 million

In general, these estimates should be interpreted with caution because they are so conservative. But these estimates provide insight into the initial magnitude of the impact; because of the complex financial planning that must go into ensuring the operational stability of health centers, it is not possible to wait until perfect data become available. Early estimates such as these are critical to understanding the implications of national policy shifts.

3. The near-term loss of Medicaid coverage among health center patients can be expected to result in the immediate loss of up to \$85 million in Medicaid revenues. These losses translate into care for up to 166,000 uninsured patients, as well as the loss of as many as 131 “new start” health centers in the nation’s poorest counties.

A conservative estimate – adjusted to assume that health centers will be able to assist their patients in re-securing coverage and minimize what otherwise might be many more months of disruption – suggests that patients’ coverage loss will have immediate and major financial implications for health centers. We estimate that Medicaid coverage disruptions for currently enrolled patients could cost health centers near-term losses of between \$28 and \$85 million in Medicaid revenues. This figure does not take into account losses connected with the denial of coverage to current and future uninsured patients who apply for medical assistance. Nor does this estimate account for the additional costs that health centers can be expected to incur as they allocate additional staff time to assisting patients experiencing disruption and delay because of the new documentation requirements.

It is important to understand what these financial losses mean in terms of real services and real patients. These anticipated losses translate into:

- Services for an additional 55,000 to 166,000 uninsured patients (\$515 per uninsured patient in 2005 dollars), as grant funding is shifted to cover the cost of care for Medicaid eligible patients seen on an uninsured basis.
- Major staffing²¹ reductions of 27 to 83 physicians, 21 to 66 dental professionals, 6 to 18 pharmacists, 11 to 33 mental health professionals, and 46 to 140 nurses and physician assistants.
- Loss of 43 to 131 “new start” health centers in the nation’s poorest counties as funds are shifted to cover Medicaid eligible patients served on an uninsured basis.²²
- An average loss of one percent of all health center operating revenues and the entire operating surplus reported by health centers in 2005. For health care providers, modest surpluses offer a critical buffer against unforeseen emergencies in their service areas.

These are the quantifiable losses. Also lost is the ability to properly manage care in the case of patients with specialty health care and referral needs. While studies show that health centers furnish primary health care of equal quality to patients regardless of insurance status, research also shows that health centers experience serious barriers to appropriate care in the case of uninsured patients who need referral services for serious and chronic health conditions.²³

Discussion

Despite a lack of evidence suggesting problems with previous verification procedures, Congress enacted stringent new documentation requirements as part of the DRA. This analysis reinforces what already has been shown in the literature: increasing the documentation burdens associated with applying for and retaining Medicaid can disrupt, delay, and ultimately drive down coverage, thereby jeopardizing health centers’ ability to furnish appropriate health care, as well as serve a growing uninsured population as their grant revenues grow increasingly strained.

The DRA documentation requirements are particularly difficult to overcome because of regulatory restrictions on what qualifies as acceptable proof, the difficulties and cost associated with producing documents, and the lack of clarity regarding the role that outstationing at health centers can play in mitigating problems. Even individuals who obviously are citizens, such as infants born in U.S. hospitals, must comply. Recent clarification guidance by CMS may only have limited impact because the new standards are limited to infants born to already enrolled women.

Health center patients may be more fortunate than most beneficiaries who face the loss of coverage. Health centers will continue to furnish care on a sliding-fee

basis and their on-site enrollment assistance may limit the duration of loss and future application denials. Yet both patients and health centers will feel the loss, not only because the reduction in revenues can be expected to impair health center services, but also because of the increased difficulties health centers face when attempting to find specialty care for uninsured patients.

These findings suggest the importance of expanded health center outstationing assistance, as some states are beginning to do. They also suggest the need to revise existing regulatory requirements to permit the use of copies, as well as provision of coverage to otherwise eligible applicants while the process of securing documents is being completed.

In the long run, these findings call into question the wisdom of legislative requirements that so significantly add to the burden of Medicaid enrollment. Documentation rules already apply to legal residents; as a result, it may be citizens who are feeling the heaviest effects of these new requirements. Furthermore, the barriers identified in this survey suggest that ultimately, the delay and disruption in enrollment will affect not only the quality of health care but also access to care at all for uninsured community residents.

Appendix: Study Methodology

National Survey

As part of the larger George Washington University Geiger Gibson Program (GW) research effort to understand the effect of the identification and citizenship documentation requirements on safety net providers, GW conducted an on-line survey to assess the impact of these requirements on health centers nationwide. The survey was sent to a random sample of 300 health centers. With assistance from the National Association of Community Health Centers, state Primary Care Associations, health center networks, and community-based organizations, we received responses from 139 health centers representing 44 states. While additional providers responded to the survey due to aggressive public outreach, we included only those on the original list to ensure a valid sample. In order to minimize reporting bias, every effort was made to solicit responses from health centers regardless of whether they had experienced an impact. The final response rate was 46 percent, or 139 of 300 health centers.

Impact Estimates

The patient and revenue estimates are based on data from the 2005 Uniform Data System (UDS) and the Center for Budget and Policy Priorities (CBPP) impact rates for the adult and child population.²⁴ The rate of denial/disruption may vary depending on certain factors, such as income level less than or greater than \$25,000, urban/rural location, and race/ethnicity of the beneficiaries. However, CBPP set its estimates based on families with an annual income of less than \$25,000, concluding an estimated 10.3 percent of children under 19²⁵ and 8.1 percent of adult Medicaid beneficiaries born in the U.S. are likely to experience either coverage disruptions or denials. Because all health center users are likely to be low-income and meet state eligibility levels, we estimate the number of Medicaid users who may lack appropriate documentation using the following formula:

$$\begin{aligned} & \text{Age-adjusted Medicaid users (minus non-Medicaid SCHIP enrollees) *} \\ & \quad 88\% \text{ non-disabled * } 90\% \text{ U.S. citizens * CBPP rate} \end{aligned}$$

Because the health center data do not provide citizenship data and the majority of Medicaid recipients are citizens or nationals of the U.S. or qualified aliens, nearly all Medicaid users are likely to be affected. In fact, one study found illegal immigrants accounted for less than one percent of Medicaid spending in North Carolina.²⁶ However, in order to appropriately apply the CBPP rates, which are based on a survey of U.S. citizens with Medicaid, we assumed 90 percent of health center Medicaid users are U.S. citizens, which is based on the CBPP estimate of 93 percent of Medicaid enrollees who are U.S. citizens²⁷ and the large volume of immigrant patients served by health centers.

Due to lack of more detailed health center Medicaid user data, we again applied as conservatively as possible the 10.3 percent and 8.1 percent rates to users by first excluding those who are least likely to be affected. Similar to CBPP's methodology, we excluded *all* newborns (especially since the UDS does not distinguish payer source for each birth) from the child user estimates and those most likely to be dually enrolled in Medicaid and Medicare.²⁸ We assumed 12 percent of child and adult Medicaid users are disabled based on the 2002 health center user survey.²⁹

Additionally, we excluded non-Medicaid SCHIP users from the calculation. While the documentation requirements apply to Medicaid and Medicaid-SCHIP programs, it may not apply to non-Medicaid SCHIP programs. In most cases, the UDS identifies the number of persons enrolled in both Medicaid and non-Medicaid SCHIP programs. However, if health centers fail to correctly report the number of SCHIP enrollees, we used CMS SCHIP enrollment data to estimate the proportion of users likely to be enrolled in SCHIP. The estimated number of adult users also excludes those enrolled in separate SCHIP programs.

Because of the crude methodology involved, a range of estimates are provided. The higher estimate approximates the result of the calculation above to the nearest hundred. This estimate is then adjusted downward on the assumption that vital records matches may make proof of citizenship easier for two-thirds of the U.S. born population.³⁰ All estimates are rounded to avoid the perception of a precise calculation.

We also estimated health center financial risk and impact on staffing using the affected population estimates and average state revenue per Medicaid patient. Revenue loss is calculated based on health center per patient revenue and half of the estimated population likely to be affected. This estimated loss in Medicaid revenue is halved to adjust for our assumption that coverage may be reinstated after six months of coverage loss. Staffing loss is calculated based on the percentage loss in total revenue and key health center staffing data from the UDS.

Based on the methodology described above, we estimated an average loss of one percent in total revenues. This estimated revenue loss, while not large, is likely to have a significant impact on those health centers at greatest financial risk for closing sites, reducing services, or limiting enrollment. Using 2004 UDS revenue and expenditures data (because the federal government has withheld release of 2005 grantee level data), we determined that approximately one out of every four health centers operates at a margin (or revenue-cost ratio) of 90 percent. Specifically, 25 percent of health centers – which represent nearly 1,200 sites – reported revenues covered up to 90 percent of costs. Margin is used because the health center data provides cash revenue and accrual cost which cannot be used to directly calculate profit or loss. The 90 percent margin provides a conservative point at which health centers are likely to be financially

vulnerable. In other words, these health centers are much more sensitive to any significant loss in Medicaid revenue, and therefore, the loss is likely to have a greater adverse impact than on health centers with a margin greater than one.

We again emphasize that we cannot predict the actual number of users who will lose coverage. Without current Medicaid enrollment data, varying level of state enforcement, as well as degree of supportive activities (e.g., linked birth records and eligibility systems) and health center efforts to mitigate the impact (e.g., outreach and use of financial reserves), it is not possible to predict accurately the number of users that will be affected.

¹ 42 U.S.C. §1396a(a)(55)

² National Association of Community Health Centers. *State Medicaid Outstationing Compliance as of August 2005*. <http://www.nachc.com/advocacy/files/Chart%203%20outstationing.pdf> (Accessed April 15, 2007)

³ 42 U.S.C. §1396b(w)

⁴ Id.

⁵ DuBard CA and Massing MW, 2007. "Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants." *JAMA* 297:10 1085-1092 (March 14)

⁶ 42 U.S.C. §1396b(i)(22)

⁷ Grady A, 2007. *Medicaid Citizenship Documentation*. Congressional Research Service, Report for Congress. (March 26)

⁸ Id.

⁹ 42 U.S.C. §1396b(x) added by §6036(a)(2), P.L. 109-171 (109th Congress, 2d Session)

¹⁰ P.L. 109-432 (109th Congress, 2d Session)

¹¹ Id.

¹² 71 Fed. Reg. 39214 (July 12) For an analysis of the interim final rule, see Judith Solomon and Andy Schneider, *New HHS Regulations Focus Medicaid Documentation Requirement on U.S. Citizen Families*. Center on Budget and Policy Priorities, Washington, D.C. <http://www.cbpp.org/7-13-06health.htm> (Accessed April 7, 2007)

¹³ *Medicaid Citizenship Documentation*, op. cit.

¹⁴ Centers for Medicare and Medicaid Services, *All Low Income Newborns to Receive Equal Access to Medicaid*. (Press release, March 20, 2007) <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=2091&intNumPerPage=10&checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date> (Accessed April 7, 2007)

¹⁵ Id.

¹⁶ Id.

¹⁷ Ku L and Broaddus M, 2006. *New Requirement for Birth Certificates or Passports Could Threaten Medicaid Coverage for Vulnerable Beneficiaries*. Center on Budget and Policy Priorities. <http://www.cbpp.org/1-5-06health.pdf> (Accessed April 7, 2007)

¹⁸ Ross DC, 2007. *New Medicaid Citizenship Documentation Requirement is Taking a Toll*. Center on Budget and Policy Priorities. <http://www.cbpp.org/2-2-07health.pdf> (Accessed April 7, 2007)

¹⁹ Hegeman R. "Nearly 20,000 Kansans lose Medicaid benefits." AP Wire, March 28, 2007.

²⁰ Id.

²¹ Staffing estimates based on 2004 UDS data owing to the decision by HRSA to withhold 2005 UDS staffing data.

²² The National Association of Community Health Centers estimate "new starts" require approximately \$650,000 apiece in start-up grant funding.

²³ Gusmano M, Fairbrother G, and Park H, 2002. "Exploring The Limits Of The Safety Net: Community Health Centers And Care For The Uninsured." *Health Affairs* 21(6):188-194 (Nov/Dec)

²⁴ Ku L, Ross DC, and Broaddus M, 2006. *Survey indicates the Deficit Reduction Act jeopardizes Medicaid coverage for 3 to 5 million U.S. citizens*. Center on Budget and Policy Priorities, February 17, 2006, revised.

²⁵ Although the CBPP survey question asks if at least one child in the household does not have a birth certificate or U.S. passport, we assume all children are likely be affected.

²⁶ DuBard and Massing, op. cit.

²⁷ Ku L and Broaddus M, op cit.

²⁸ Ku L. *Revised Medicaid documentation requirement jeopardizes coverage for 1 to 2 million citizens*. Center on Budget and Policy Priorities, July 13, 2006.

²⁹ Although the prevalence of disability ranges from 8-12 percent, we purposefully chose 12 percent to produce a conservative estimate. The estimates are based on reports from the 2002 CHC User/Visit Survey.

³⁰ Ku L, op cit.