ISSUE BRIEF

Medicare/Medicaid Technical Assistance #93:

The Impact of the Deficit Reduction Act Citizenship Documentation Requirement on Special Populations

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On February 8, 2006, Congress enacted the $39 billion Deficit Reduction Act of 2005 (DRA)[1] The legislation cleared the way for potentially dramatic changes in Medicaid law and set in motion numerous policy changes, which were intended to reduce federal Medicaid spending. One of the most controversial measures was (and remains) Section 6036 – the Medicaid Citizenship Documentation Requirement (the Requirement), requiring all individuals who are initially applying for or renewing their Medicaid coverage on or after July 1, 2006 to provide one or more of the proscribed documents to verify their U.S. citizenship and proof of personal identity.[2] The Requirement was intended to prevent undocumented persons from fraudulently enrolling in Medicaid. In practice, however, it threatens Medicaid coverage for millions of eligible U.S. citizens who lack the necessary documentation.

Complying with the Requirement can be challenging for health centers and their low-income patients for several reasons, including:

1) The complexity of the application process,
2) The difficulty in and potential cost of obtaining and maintaining documentation, and
3) The increased administrative burdens.

To effectively assist their special populations in complying with the Requirement, it is imperative that health centers understand the distinct challenges faced by such populations in establishing U.S. citizenship, and how to overcome these challenges to ensure the continued availability of Medicaid coverage for such individuals.

This issue brief:

- Provides an overview of the Requirement, including the final implementing rules;
- Explores the impact of the Requirement on Medicaid populations in general, as well as its impact on health centers and their patients;
- Explores additional challenges faced by special populations in establishing U.S. citizenship; and
- Provides additional resources to resolve concerns and to better serve special populations.

[1] 42 U.S.C. §1396b(x), added by P.L. 109-171 and subsequently amended in the Tax Relief and Health Care Act , P.L. 109-432 (enacted on December 20, 2006).

OVERVIEW OF THE MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENT

Prior to the enactment of the Requirement, states were required by Federal law to obtain written declarations from Medicaid applicants regarding their citizenship status -- although many states satisfied this requirement through verbal declarations in lieu of written documents. Often, states would request written documentation of citizenship only if the applicant's U.S. citizenship was believed to be doubtful. Applicants who declared that they were not U.S. citizens were required to provide documentation of their legal immigration status.

With certain explicit exemptions, the Requirement requires all individuals who are initially applying for or who are renewing their Medicaid coverage on or after July 1, 2006, including persons eligible for Medicaid under a Section 1115 demonstration project, to present "*satisfactory documentary evidence of citizenship or nationality*," which includes presentation of documentation verifying both U.S. citizenship and personal identity.[3]

States will not receive Federal matching funds for any person who:

1. Declares him or herself to be a citizen;
2. Is not exempted from the Requirement; and
3. Does not meet the Requirement.

It is important to note that the Requirement applies solely to individuals who would otherwise be eligible for Medicaid benefits (*i.e.* U.S. citizens and documented immigrants). Further, the Requirement does not present any change in procedure for non-citizen immigrants.

- Non-citizen documented immigrants who may be eligible for Medicaid do not need to submit a U.S. birth certificate or passport to satisfy the Requirement – rather, they would be required to submit their immigration documents as they did prior to the enactment of the Requirement; and

- Undocumented persons who are ineligible for general Medicaid benefits may still be eligible for emergency Medicaid coverage without having to meet the Requirement.

[3] For purposes of this Information Bulletin, the terms "citizenship" and "citizen" include both U.S. citizens and persons with status as a "national of the United States" as defined by Section 101(a)(22) of the Immigration and Nationality Act (*i.e.*, non-citizen nationals).

On July 13, 2007, the Centers for Medicare and Medicaid Services (CMS) published a final rule to implement the Requirement.[4] As noted above, the rule exempts the following populations from having to meet the Requirement in order to obtain or maintain Medicaid coverage:

- Individuals eligible for or enrolled in Medicare (Part A or Part B) beneficiaries;
- Recipients of Supplemental Security Income (SSI);
- Recipients of Social Security Disability Insurance (SSDI); and
- Children receiving federal adoption assistance or in foster care.

Presumptive Eligibility

Presumptive eligibility can still be granted without U.S. citizenship documentation for pregnant women, children under the age of 19, and women eligible for breast and cervical cancer screening, in accordance with Sections 1920, 1920A and 1920B of the Social Security Act. However, once a presumptively eligible person submits a Medicaid application in which the person declares his/her U.S. citizenship, he or she must also present the U.S. citizenship and personal identity documentation as discussed in greater detail below.

Newborn Children

Newborn children of all women who are eligible for and receiving Medicaid at the time of birth (regardless of the mother's immigration status or the scope of benefits to which she is entitled), will be eligible for Medicaid for up to 1 year, provided that the mother remains Medicaid-eligible (or would remain so if she was pregnant) and the child is a member of her household.

Levels of Citizenship Documentation

The rule describes four levels of documents which can be used to establish U.S. citizenship, listed in descending order of their reliability. Recipients must first attempt to present documents from the primary list before proceeding to the secondary list (and, if necessary, the levels that follow). States have the discretion to determine when a document of a higher level is unavailable.

[4] *See* 72 *Fed Reg* 38662, *et seq*., modifying 42 CFR §§435.117, 435.406, 436.117 and 436.406, and adding new sections §§435.407 and 436.407.

Primary Documentation

Primary documentation is documentation of the highest reliability that establishes both U.S. citizenship and personal identity, and includes

- U.S. passports,
- Certifications of naturalization or of U.S. citizenship, and
- State-issued driver's licenses provided that the state requires proof of U.S. citizenship prior to issuance.

Non-Primary Documentation

Non-primary U.S. citizenship documentation must be accompanied by separate documentation establishing personal identity. Examples of non-primary forms of documentation are listed below.

Secondary documentation includes (but is not limited to):

- Birth certificates and other birth/adoption records in place of a birth certificate -- states may use vital records match to document a birth record;
- U.S. citizen identification card;
- Evidence of U.S. civil service employment before June 1, 1976;
- U.S. military record showing a U.S. place of birth;
- Data verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) Program database for naturalized citizens.

Third level documentation includes, but is not limited to:

- Hospital records that indicate a U.S. place of birth and that were established at time of birth and created at least five years before the initial Medicaid application;
- Life, health or other insurance records that indicate a U.S. place of birth and that were created at least five years before the initial Medicaid application;
- Religious records recorded in the U.S. within 3 months of birth demonstrating that the baby was born in the U.S. and that show either the date of birth or the individual's age at the time the record was made;
- Early school records showing a U.S. place of birth and date of birth, as well as names and places of birth of the child's parents.

Fourth level documentation includes (but is not limited to):

- Federal or state census record that indicate U.S. citizenship or a U.S. place of birth.
- Institutional admission papers or medical (clinic, doctor, or hospital) records that indicate a U.S. place of birth and that were created at least 5 years before the initial Medicaid application date.

If an individual cannot obtain any of the documents listed in the rules, citizenship documentation may be provided in a written affidavit signed, under penalty of perjury, by two U.S. citizens who have specific knowledge of the individual's U.S. citizenship or naturalization status. One of the citizens must not be related to the individual and both must prove their own U.S. citizenship and personal identity. Additionally, the individual must submit an affidavit explaining why he/she cannot obtain documentary evidence. CMS emphasizes that written affidavits (as well as any and all fourth level documentation) should be used only in rare circumstances.

Personal Identity Documentation

As noted above, if an individual presents secondary, third level, or fourth level documentation to verify his/her U.S. citizenship, he/she must also present separate documentation establishing personal identity. Examples of documents that establish personal identity include:

- Driver's license with photo or other types of identification cards;
- Clinic, doctor, hospital pr school records for children under the age of 16;
- If no other forms of identity documentation are available for children, an identity affidavit signed by a parent, guardian or caretaker relative and stating the date and place of birth (cannot be used if an affidavit for U.S. citizenship was presented);
- An identity affidavit for individuals with disabilities residing in residential care, signed by the facility director.

If no other forms of identification are available <u>and</u> U.S. citizenship was verified through second or third (but not fourth) tier documents, identification can be established through 3 or more corroborating documents with the individual's name and consistent identifying information, provided that the documents were not also used to establish citizenship.

The Documentation Process

All documents verifying U.S. citizenship and/or personal identity must be originals or copies certified by the issuing agency and may be submitted either in person at the Medicaid office or through the mail. Nevertheless, in the preamble, CMS acknowledged that, as part of its outstationing activities, an employee of a federally qualified health center (FQHC) can collect and photocopy an applicant's documentation and certify that

the original documents were seen by the FQHC, thus obviating the need for the applicant to send in the **original** document to the State Medicaid agency.

Further, once U.S. citizenship has been proven, it does not have to be documented again when the individual renews his/her Medicaid eligibility unless later evidence raises questions about his/her citizenship.

The rule requires that individuals be given a "reasonable opportunity" to submit citizenship documentation. CMS does not define "reasonable opportunity," stating instead that it should be consistent with the state's administrative requirements and should not exceed federal rules for timely eligibility determinations. CMS also notes that states should not expect an individual to purchase a higher level document that cannot be made available within the "reasonable opportunity period" if a lower level document is available.

An individual renewing his/her Medicaid eligibility will remain eligible during the time period in which he/she is making a "good faith effort" to obtain and present the necessary documents (and until they are determined ineligible for a failure to do so). New applicants who are not presumptively eligible, however, will not be considered eligible for benefits until documentation is presented (*i.e.*, no interim benefits), regardless of whether they have satisfied all other eligibility requirements.

If an individual is unable to comply with the requirements due to incapacity of mind or body, and lacks representation to assist them, the Requirement requires states to assist them in securing sufficient documentation. Nevertheless, the rule does not define an acceptable level of assistance, nor does it make significant concessions for high-risk populations (*e.g.*, homeless individuals).

IMPACT OF THE MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENT

Impact on Medicaid Populations

As noted above, new Medicaid applicants who are not presumptively eligible will not be eligible for, nor will they receive, Medicaid benefits until U.S. citizenship documentation is presented. Initially, it was anticipated that this limitation on interim benefits would result in devastating consequences for Medicaid populations - delaying necessary care while individuals secured sufficient documentation as well as increasing utilization of hospital emergency rooms for non-urgent care in lieu of obtaining the documentation. Many of those predications have been proven correct, as discussed in greater detail below.

In 2006, prior to implementation of the Requirement, a nationally representative survey commissioned by the Center on Budget and Policy Priorities indicated that millions of

low-income U.S. citizens would be disproportionately impacted by the citizenship documentation requirements.[5] According to this survey, approximately 49 million U.S.-born citizens (and 2 million naturalized citizens) who are covered by Medicaid over the course of a year would be required to submit documents verifying their U.S. citizenship or forfeit their health insurance coverage.

Other key findings from the study included:

- **About one in every twelve (or 8 %) U.S.-born adults age 18 or older who have incomes below $25,000 reported they do not have a U.S. passport or U.S. birth certificate in their possession.** Applying this percentage to the number of adult citizens covered by Medicaid over the course of a year indicates that approximately 1.7 million U.S.-born adults who are covered by Medicaid could lose their health insurance because of the Requirement or experience delays in obtaining coverage as they attempt to secure these documents.

- **More than one tenth of U.S. born adults with children who have incomes below $25,000 reported they did not have a birth certificate or passport for at least one of their children.** This indicates that between 1.4 and 2.9 million children enrolled in Medicaid appear not to have the paperwork required.[6]

- Since implementation of the Requirement, **reports nationwide indicate that a significant number of persons who have lost or been denied Medicaid coverage resulting from the Requirement were in actuality citizens who lacked birth certificates and other documentation.**[7]

- **Many states also report decreased enrollment (especially among low-income children), along with increased administrative costs, application backlogs and delays,** and difficulties in addressing the additional complexities of the application process.

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[5] *See* Leighton Ku et al., *Survey Indicates Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 million U.S. Citizens* (Feb. 17, 2006), at http://www.cbpp.org/1-26-06health.htm.

[6] For children under age 16, an affidavit by the parent or guardian stating the child's date and place of birth may be used, but only if none of the other allowable identity documents is available.

[7] The states reporting this finding represent a cross-section of the nation; among them are Florida, Iowa, Kansas, Louisiana, New Mexico, Ohio, Virginia, Oregon, Wisconsin and Kansas.

A report by the Congressional Research Service (CRS) indicates that:

- **Implementation of the Requirement has resulted in increasing state administrative costs,** subjecting citizens to disparate treatment and affecting some children attempting to enroll in the State Children's Health Insurance Program.[8]

- **The majority of individuals denied Medicaid coverage for failure to meet the Requirement may be U.S. citizens**, backing up anecdotal claims from states and providers.

Recently the Government Accountability Office (GAO) released a detailed report. GAO surveyed all 50 states and the District of Columbia to evaluate the effect of the Requirement on individuals' access to the Medicaid program, and the administrative and fiscal burden of implementing the Requirement imposed on states, individuals and the federal government.[9] The GAO received complete responses from 44 states, representing 71% of the national Medicaid enrollment in fiscal year 2004. In general, states reported that the Requirement resulted in creating barriers in accessing Medicaid benefits for both new applicants and individuals seeking re-determination.

Access to the Medicaid Program

- **Twenty-two (22) reported a decline in Medicaid enrollment** since implementing the Requirement. Further, a majority of those states attributed the declines to delays, denials or losses of coverage <u>for individuals who appeared to be eligible citizens</u>.

- Of the 22 states, all reported an **adverse impact on enrollment of childre**n.

- Twenty-one (21) states reported an **adverse impact on adult enrollme**nt, including pregnant women and the aged, blind and disabled.

- One reported that during first 7 months, **18,000 applicants were denied or had coverage terminated** for inability to provide documentation, even though the state believed them to be citizens.

- A vast majority **expected the downward enrollment trend to continue** (although they varied in anticipated length of time).

[8] *See Medicaid Citizenship Documentation*, Congressional Research Service (March 22, 2007).

[9] *See "States Reported That Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens"* (GAO-07-889, June 2007).

It was believed that variation in the effect on Medicaid access may have been influenced by factors such as: 1) Individual state enrollment policies (*e.g.*, states depending primarily on mail-in enrollment experienced a high amount of decline; states that had documentation policies in place prior to the Requirement experienced either no or little decline) and/or 2) whether the individual was an initial applicant or an existing beneficiary applying for re-determination, with new applicants affected more adversely.

Administrative Burdens to Implement Rule

With respect to administrative burdens, all states established administrative measures to assist in implementing the Requirement, including training of eligibility workers, revised applications and re-determination forms, data matches with the state's vital statistics agency, and modified information technology systems. Nevertheless, most states reported that the Requirement resulted in increases in the number of applicants needing additional in-person assistance and in the amount of time spent on completing applications and re-determinations.

More than 80% of the states reported facing administrative challenges in implementation, many attributing those challenges to two aspects of the rule:

- The requirement that documents be originals (or copies certified by the issuing agency) resulted in: (1) barriers for eligible citizens because of the cost of obtaining documents; and (2) an increase in the volume of in-person enrollment.[10]

- The list of acceptable documentation was viewed as too complex and lacking state discretion to allow exceptions.

Financial Burdens

Finally, GAO concluded that the estimates of financial benefits to both federal and state governments ($90 million in total savings) may have been overstated for two reasons: (1) it did not account for increased administrative costs; and (2) the intended effect of preventing ineligible persons from receiving Medicaid benefits may be less prevalent than anticipated.[11]

[10] Interestingly, health centers from one state report that the state accepts faxed documents, despite the specific limitations as to the acceptable form for documentation.

[11] In response to the report, CMS agreed that the Requirement poses challenges. However, it raised concerns regarding both the sufficiency of the underlying data, as well as the "vague" and "subjective" nature by which states were asked to specify the reasons behind the enrollment declines. CMS stated its belief that administrative costs and other challenges will decrease over time (a belief not shared by the States that responded to the survey).

Impact on Health Centers

A recent study conducted by the George Washington University (GWU) resulted in findings among health centers and their patients that mirror those related to Medicaid populations in general, but are more troubling in their degree.[12] Findings from the report include:

Enrollment

- More than 90% of health centers studied reported enrollment difficulties for one or more patient populations.
- Nearly 1/2 reported that their patients experienced application-related problems, including longer application and enrollment processes, applications lacking sufficient documentation, delays in securing documentation and having to pay to obtain documentation.
- More than 1/3 reported that they had to increase staff time to assist in the application process.
- Nearly ½ reported that the delays and disruptions in the application process affected their ability to arrange for specialty care, while 1/3 reported difficulties in securing health care access, including hospital inpatient deliveries for pregnant women.

Financial Impact

Also disturbing for health centers is the Requirement's potential effect on revenue. As the largest insurer of health center patients, adequate Medicaid payments are essential to a health center's financial wellbeing. Medicaid represents 37% of total revenue for FQHCs - the largest of any single source - and is directly proportional to the percent of patients with Medicaid.[13] However, more than 20% of health centers surveyed by GWU reported a decrease in enrollment of Medicaid patients, with 2/3 identifying the new Requirement as the cause of such declines. Undoubtedly, health centers experiencing decreases in Medicaid enrollment among their patients are also seeing corresponding decreases in Medicaid revenue.

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[12] *See* Shin, Peter, et. al., *An Initial Assessment of the Effects of the Medicaid Documentation Requirements on Health Centers and Their Patients*, The George Washington University, School of Public Health and Health Services, Department of Health Policy (May 7, 2007).

[13] NACHC fact sheet - Health Centers and Medicaid

The decrease in Medicaid enrollment may have an additional adverse financial effect on health centers beyond the loss of Medicaid revenue. Insofar as most, if not all, of the health center patients who lose their Medicaid coverage will become uninsured, more than likely health centers will see a significant increase in the number of uninsured patients they treat. GWU estimates that the decrease in Medicaid revenue may also impact the ability to support care to anywhere between 55,000 and 166,000 uninsured individuals because of revenue shortfalls (which Section 330 grant funds will not be available to cover) and will likely result in staffing decreases nationwide.

Potential Support

One way to deflect some of the negative impact on Medicaid enrollment would be to secure assistance from State Medicaid agencies (which ultimately are responsible for compliance with the Requirement), both from the outset and on an ongoing basis. Anecdotal evidence among health centers suggests that states vary in the type and amount of assistance provided. Some health centers report that they have received little (or no) assistance from the state Medicaid agency, while others indicate that their state has been very supportive of the efforts of health centers to implement and comply with the Requirement. Examples of such support include:

- Supporting citizenship and personal identity verification through the use of vital statistics matches.
- Initiating data matches with other state and federal databases.
- Developing documents highlighting the changes to the Medicaid eligibility and enrollment processes and the state's expectations, which, in turn, were distributed to all counties and stakeholders, including health centers, health center consortia and Primary Care Associations (PCAs).
- Providing other information throughout the implementation process.
- Developing a specific website for health centers to enroll patients.

Other centers report that their respective PCA, rather than the Medicaid agency, has been instrumental in providing necessary assistance by furnishing training either to health center consortia staff (who, in turn, would train the health center staff) or directly to health centers. Despite these supportive efforts, centers continue to see decreases in Medicaid enrollment - one center from a very supportive state reported only a 70% success rate in obtaining Medicaid benefits for eligible citizens (down from nearly 100% prior to implementation of the Requirement).

ADDITIONAL CHALLENGES FACED BY SPECIAL POPULATIONS IN ESTABLISHING CITIZENSHIP

Many of the issues which make compliance with the Requirement difficult for the low-income population in general are exacerbated by the unique characteristics of special populations, such as migrant and seasonal farm workers (MSFWs), homeless individuals and families, and public housing residents. For example:

- Linguistic and cultural differences may result in barriers to disseminating information regarding the Requirement and the documentation needed to comply.

- The lack of necessary documentation coupled with the cost of obtaining documents and the complexity of the application itself which may prove too daunting.

- Population mobility which may result in loss of documentation, inability to secure out-of-state documents and/or difficulty in complying with a lengthy and time consuming application and enrollment process.

- Fear, mistrust and/or suspicion of government and the health care system may cause otherwise eligible persons to avoid producing necessary documentation.

Linguistic and Cultural Barriers to Disseminating Information

As with all requirements related to receiving health care services, it will be difficult for patients to comply with the Requirement if they are not aware of what is expected of them and how health centers are prepared to assist them in the application process. Linguistic and cultural differences could create additional barriers in disseminating this information to certain special population patients.

Health centers should provide special populations with culturally and linguistically appropriate information (taking into account factors such as literacy, countries and cultures of origin and demographic trends) regarding:

- The existence of the Requirement;
- Available services to assist in meeting the Requirement, and
- The appropriate manner in which to utilize assistance services to minimize any delays or disruptions in Medicaid coverage.

Medicaid application and enrollment assistance provided by the health center may require personnel who are bilingual, as well as staff who can assist patients with linguistic challenges and/or cultural sensitivities with all aspects of the application process,

including support in completing complicated forms and in meeting the verification requirements.[14] Cultural and linguistic sensitivity concerns should be considered and addressed not only by health center staff, but also by Medicaid outstationed eligibility workers employed by the Medicaid agency and assigned to the health center.

Note that in addition to your health center's specific information dissemination and application assistance strategies, CMS has launched an outreach program to educate states and interested groups about the Requirement. This outreach program includes presentations and tools, consisting of talking points, questions and answers, a sample press release, drop-in article and lists of acceptable documents, that may be used to help applicants and recipients understand the Requirement.[15] In addition, CMS has stated that it will work closely with states to help them reach out to their current Medicaid enrollees and the general public outlining the new rules.

Lack of Documentation, Expense of Obtaining Documentation, and Application Complexity

As previously discussed, many health centers report that their patients, in general, have experienced application-related problems, including:

- Delays in securing necessary documentation,
- Expenses related to obtaining original or replacement documentation, and
- Lengthy, time-consuming, and complex application and enrollment processes.

While difficulties such as these impact all health center patient populations, they may be magnified for certain special population patients who lack the time, access to documentation, and/or financial resources to address these challenges. Some health centers report difficulties experienced by their special population patients due to the lack of organizational skills necessary to complete an arduous verification and application process.

Rather than attempting to overcome the challenges, individuals may forgo completing an application or renewal form if it is excessively complicated or may give up attempting to obtain citizenship documentation if it is too cumbersome or too expensive to do so. Either way, the result is the same – individuals relinquishing the benefits to which they are entitled because of unworkable bureaucratic procedures.

[14] A sampling of websites that provide information on cultural competency and interpreter training as well as educational materials are: http://www.diversityrx.org/; http://www.xculture.org/; http://gucchd.georgetown.edu/; http://www.nmci.org/; http://erc.msh.org/.

[15] For printable posters and brochures, visit the CMS website at http://www.cms.hhs.gov/MedicaidEligibility/05_ProofofCitizenship.asp.

Several studies and reports indicate similar results, *i.e.*, that one of the most serious and pervasive obstacles to Medicaid enrollment for special populations across all eligibility categories is the lack of required documentation to confirm eligibility. Factors contributing to unavailability or lack of ready access to necessary documentation include lack of permanent housing, transportation and continuous employment. Obtaining required documentation is often costly, time-consuming and intimidating, and special populations (especially migrant farm-workers and homeless individuals) may have no safe place to maintain it, once it is obtained.

The final rules permit individuals to provide documentation via a written affidavit, signed under penalty of perjury, from two citizens (one of whom cannot be related to the applicant or recipient), who have specific knowledge of a beneficiary's citizenship or naturalization status. However, insofar as special population patients may have difficulty in finding two citizens who have personal knowledge of their status, such affidavits are not apt to be a realistic option for special population patients.

As for the application process itself, the Requirement allows individuals to mail documentation to the Medicaid agency rather than appearing in person. However, once the documentation is obtained, special population patients may be reluctant to submit original documentation by mail for fear of not having it returned and may be unable to obtain or afford copies certified by the issuing agency to mail in lieu of originals. With certain exceptions (*e.g.*, outstationed eligibility), individuals who do not want to mail documentation will be required to present in person to the Medicaid agency. Assuming that to present in person would require individuals to take off time from their jobs, this requirement could significantly disadvantage certain special population patients financially, in terms of both forfeiting pay and procuring access to transportation.

Support from Health Centers

- The preamble to the final rule indicates that as part of its outstationing activities, an employee of an FQHC:
    1. Can collect and photocopy an applicant's documentation,
    2. Certify that the original documentation was seen by the FQHC, thus obviating the need for the applicant to send in the original document to the State Medicaid agency or to appear in person.
    3. Ensure the placement of outstation eligibility workers in their respective facilities or to enter into agreements to utilize health center staff for such activities.

- To overcome some of the application delays and disruptions from the outset, it is advisable for health center staff to: Inform their current Medicaid patients of the Requirement well in advance of their Medicaid renewal date. Patients should be informed that the documentation process can be time consuming and should be initiated well ahead of applicable deadlines if possible. This is particularly important for patients whose documentation must be obtained

through out-of-state agencies, which may add extra layers of complexity and, thus, additional time delays in securing documentation. (For additional information regarding out-of-state documentation, please see the section below which addresses population mobility).

- Further, health centers serving special populations should examine their enhanced outreach and case management activities to ensure that they incorporate information regarding compliance with the Requirement (and should set aside funds in their budgets to implement any additional procedures necessary to accomplish this). Initiating the information process early (*i.e.*, as part of the case management and outreach performed at homeless shelters, MSFW camps, and neutral facilities within public housing developments) will help patients prepare to comply with the Requirement when they present to the health center.

- Given that the Requirement does not include a "hardship exemption" for individuals who cannot obtain documentation and do not have family or other representatives to assist, health centers may play an important role in assisting beneficiaries and applicants in obtaining some or all of the necessary documentation by facilitating the search of existing state databases. This would greatly reduce the time individuals need to comply with the Requirement, and would also lessen the financial and logistical burdens on citizens. For example:

    1. The Social Security Administration (SSA) maintains a file for all persons who have Social Security numbers. This file contains partial information on citizenship and relatively complete information on each person's place of birth. To help your client obtain a Social Security Number or a replacement Social Security card, visit the SSA website at www.socialsecurity.gov/ssnumber.

    2. The National Center for Health Statistics Web site, http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm has information about where to access vital records systems in your state, which retain birth certificate data for persons born in the state. [16] Even if staff cannot access the data directly, the health center may be able to transmit a list of potential beneficiaries to the vital records agency which can match the data. Also, to help your client locate a copy of his or her birth certificate, visit the Social Security Administration website at www.socialsecurity.gov/vitalstats.html.

[16] For general tips on helping your client access mainstream benefits programs, visit FirstStep at: http://www.cms.hhs.gov/apps/firststep/content/general_tips.html

Population Mobility

Population mobility raises some interesting issues regarding the ability of special populations to secure and submit the necessary U.S. citizenship documentation. The often transient nature of certain special populations (in particular, homeless populations and migratory farm-workers and their families) may make it more difficult for these individuals to retain documentation necessary to prove eligibility for Medicaid and other public assistance programs. Documentation can be easily lost or misplaced during a move, and the costs associated with obtaining new documentation might serve as an additional disincentive to enrollment.

Whether due to the nature of their job or the realities of their living situation, often members of special populations reside in locations that are temporary and subject to rapid change over short periods of time, as well as obscure or remote locations. Thus, obtaining appropriate documentation may mean contacting an agency located in a state that is different from the one in which the patient is currently residing. Further, if documentation is submitted to the Medicaid agency by mail, individuals who have moved on may have difficulty receiving the documentation upon its return.

Compounding these difficulties is the fact that members of mobile populations may need to continually apply for Medicaid each time they move to a new state. Insofar as complying with the Requirement one time can be difficult, doing so multiple times can be a daunting proposition.

Support from Health Centers

As medical homes to millions of patients, health centers may be able to assist those special population patients who are mobile.

- Centers can securely **house records and documents** on behalf of special population individuals (provided that the patients are willing to allow the health center to do so), either as part of the existing patient record or in separate patient citizenship/identity verification files. Maintaining this information at the health center (rather than with the mobile individuals) should help to ensure that no individual eligible for Medicaid or other assistance slips through the cracks due to inability to maintain or loss of required documentation.

- Further, health centers should be prepared to assist in **contacting and working with agencies located out-of-state** to ensure that Medicaid-eligible patients whose documentation was produced and is housed out-of-state (*i.e.*, through displacement or mobility of the patient) will be able to secure such documentation. Assistance could include:

1. Maintaining appropriate contact information, in particular, the names, phone numbers and e-mails of specific personnel;

2. Allocating staff time to help patients obtain out-of-state documentation; and

3. Allocating funds to assist in paying for out-of-state documentation. Of note, health centers that need to contact out-of-state agencies for documentation should prepare for long waiting times and, thus, should start the process as early as possible.[17]

Fear, Mistrust and/or Suspicion of Government and the Health Care System

Fear or mistrust of the health care system or of governmental assistance is one of the most significant barriers to care for certain special populations.[18] It is also common among special population patients to harbor suspicions regarding larger institutions and the people who work for them,[19] potentially including the health center. Individuals may feel estranged or alienated from the community, as well as suspicious of or resistant to accepting services out of fear, depression, or mistrust. The rejection by or the negative interactions they have experienced in the past from family, friends, health care providers, police, and the community at large could exacerbate these concerns.[20] Thus, even if individuals have the necessary documentation to satisfy the Requirement, fear, mistrust and/or suspicion could cause otherwise eligible persons to avoid producing it.

Support from Health Centers

Health centers serving special populations should consider how to inform special population patients of the Requirement while ensuring that the Requirement itself does not create a barrier to care by compounding the existing fears and suspicions of such individuals.

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[17] As reported by several health centers, efforts in contacting out-of-state agencies are not always successful.

[18] Castanares, Tina, *Migrant Health Issues Monograph Series # 5: Outreach Services*, National Center for Farmworker Health, Inc. (NCFH).

[19] *See generally* National Health Care for the Homeless Council (NHCHC), *Addressing Cultural and Linguistic Competency in the HCH Setting: A Brief Guide*, which can be accessed at www.nhchc.org/competency.html .

[20] *Id.*

1. The key is trust – to ensure that a health center's efforts to assist patients in meeting the Requirement do not create (or worsen) a barrier to care, the patients must be able to trust that the health center is working in their best interests. Careful and thoughtful explanation of the Requirement and linguistic and cultural sensitive and competency in assembling documentation should assist in building this trust.

2. Health center staff should also clarify that individuals listed on an application who are not applying for benefits for themselves do not need to submit proof of their own citizenship or immigration status, thus helping to alleviate certain fears regarding such status and the potential ramifications.[21] This is particularly important at the conclusion of the automatic eligibility period for newborns, when a Medicaid application must be filed to continue coverage for the child.

CONCLUSION

The new Medicaid citizenship documentation requirements present several universal challenges for all providers, especially those serving low-income populations, related to the complexity of the application process, the difficulty in obtaining and maintaining documentation, and the increased administrative burdens placed on both the providers and their patients. Similar to other bureaucratic demands, health centers that serve MSFWs, homeless individuals and families, and public housing residents, may face additional challenges based on the unique characteristics of these populations. These challenges include:

- **Linguistic and cultural differences** which may result in barriers to disseminating information regarding the Requirement and the documentation needed to comply.

- The **lack of necessary documentation coupled with the cost of obtaining documents and the complexity of the application** itself which may effectively force individuals to forgo completing an application or renewal form.

- **Population mobility** which may result in loss of documentation, inability to secure out-of-state documents and/or difficulty in complying with a lengthy and time consuming application and enrollment process.

- **Fear, mistrust and/or suspicion** of government and the health care system which may cause otherwise eligible persons to avoid producing necessary documentation.

[21] Center on Budget and Policy Priorities, *DRA Citizenship Documentation Requirement for Medicaid: Working with Your State on Implementation,* May 3, 2006, available at: http://www.aapd.com/News/deficit/060503dra.htm

As daunting as it may seem, ensuring continued access to Medicaid benefits for eligible special population patients who may be disenfranchised from other components of the health care system is crucial to ensuring positive health outcomes for such individuals. Accordingly, it is vital for health centers to establish processes by which they can assist their patients in complying with the Requirement, while remaining sensitive to the particular challenges, including: (1) providing early and enhanced education and information dissemination; (2) assisting in obtaining documentation by facilitating the search of existing state databases and working with out-of-state agencies; (3) maintaining records and documents on behalf of patients to safeguard against loss or misplacement; and (4) building trust so that the Requirement itself does not create a barrier to care by compounding existing fears and suspicions.

Additional Resources: Organizations with Expertise in Issues and Concerns Related to Special Population

The following is a sampling of the numerous resources available to assist health centers that serve special populations:

- **HRSA Bureau of Primary Health Care**: key program areas include Health Care for the Homeless Information Resource Center, the Migrant Health Program, and the Public Housing Primary Care Program: http://bphc.hrsa.gov/; http://bphc.hrsa.gov/Hchirc/; http://bphc.hrsa.gov/migrant/; http://www.bphc.hrsa.gov/phpc/.

- **DHHS Office on Minority Health** is the office within DHHS that can provide additional resources on matters of concern for special populations: http://www.omhrc.gov.

- **DHHS Centers for Medicaid and Medicare Services (CMS)** is the agency within DHHS that implements and oversees the Medicare program and, in conjunction with the state Medicaid agency, the Medicaid program, including the requirements for participation in those programs: http://www.cms.hhs.gov.

- **National Resource Center on Homelessness and Mental Illness** is the resource center within the Substance Abuse and Mental Health Services Agency (within DHHS) that focuses on the effective organization and delivery of services for people who are homeless and have serious mental illnesses: www.nrchmi.samhsa.gov.

- **National Health Care for the Homeless Council** is an organization that advocates for reform of the health care system to best serve the needs of people who are homeless: http://www.nhchc.org.

- **National Coalition for the Homeless** is an organization that works to meet the immediate needs of people who are currently experiencing homelessness or who are at risk of doing so. In addition to health care needs, NCH advocates for and provides information on housing justice, economic justice, and civil rights. www.nationalhomeless.org.

- **National Law Center on Homelessness and Poverty** is an organization that works to prevent and end homelessness by serving as the legal arm of the nationwide movement to end homelessness: http://www.nlchp.org/.

- **American Bar Association Commission on Homelessness and Poverty** is committed to educating the legal bar and the public about homelessness and poverty and the ways in which the legal community and advocates can assist those in need: http://www.abanet.org/homeless/home.html.

- **Farmworker Justice Fund, Inc.** is an organization that provides policy analysis on legislative issues that impact the living and working conditions of farmworkers nationwide: http://www.fwjustice.org.

- **Farmworker Health Services Inc.** is an organization that works with local communities to improve the quality of life of farmworker families, with a focus on increasing accessibility and availability of health services for farmworkers: www.farmworkerhealth.org.

- **National Center for Farmworker Health, Inc.** is an organization that is dedicated to improving the health status of farmworker families by providing information services and products, and by removing the regulatory barriers faced by workers and their families as they move between States and by enrolling more farmworkers and families in Medicaid and State Child Health Insurance (SCHIP). In addition, it conducts workshops and distributes fact sheets about how to enroll in child health programs: www.ncfh.org.

- **Migrant Health Promotion** is an organization that is committed to strengthening the capacity of farmworker families and their communities by improving health status through peer education and advocacy: http://www.migranthealth.org.