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MEDICAID

States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens





Highlights of [GAO-07-889](#), a report to congressional requesters

Why GAO Did This Study

The Deficit Reduction Act of 2005 (DRA) included a provision that requires states to obtain documentary evidence of U.S. citizenship or nationality when determining eligibility of Medicaid applicants and current beneficiaries; self-attestation of citizenship and nationality is no longer acceptable. The Centers for Medicare & Medicaid Services (CMS) issued regulations states must follow in obtaining this documentation. Interested parties have raised concerns that efforts to comply with the requirement will cause eligible citizens to lose access to Medicaid coverage and will be costly for states to implement.

GAO was asked to examine how the requirement has affected individuals' access to Medicaid benefits and assess the administrative and fiscal effects of implementing the requirement.

To do this work, GAO surveyed state Medicaid offices in the 50 states and the District of Columbia about their perspectives on access issues and the administrative and fiscal effects of the requirement. GAO obtained complete responses from 44 states representing 71 percent of national Medicaid enrollment in fiscal year 2004. GAO also reviewed federal laws, regulations, and CMS guidance.

www.gao.gov/cgi-bin/getrpt?GAO-07-889.

To view the full product, including the scope and methodology, click on the link above. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

MEDICAID

States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens

What GAO Found

States reported that the citizenship documentation requirement resulted in barriers to access to Medicaid for some eligible citizens. Twenty-two of the 44 states reported declines in Medicaid enrollment due to the requirement, and a majority of these states attributed the declines to delays in or losses of Medicaid coverage for individuals who appeared to be eligible citizens. Of the remaining states, 12 reported that the requirement had no effect and 10 reported they did not know the requirement's effect on enrollment. Not all of the 22 states reporting declines could quantify enrollment declines due specifically to the requirement, but a state that had begun tracking the effect identified 18,000 individuals in the 7 months after implementation whose applications were denied or coverage was terminated for inability to provide the necessary documentation, though the state believed most of them to be eligible citizens. Further, states reporting a decline in enrollment varied in their impressions about the requirement's effect on enrollment after the first year of implementation. States' enrollment policies and whether an individual was an applicant or a beneficiary may have influenced the requirement's effect on access to Medicaid. For example, states that relied primarily on mail-in applications before the requirement were more likely to report declines in enrollment than states where individuals usually applied in person. In addition, the requirement may have more adversely affected applicants than beneficiaries because applicants were given less time to comply in some states and were not eligible for Medicaid benefits until they documented their citizenship.

Although states reported investing resources to implement the requirement, potential fiscal benefits for the federal government and states are uncertain. All 44 states reported taking administrative measures to implement the requirement and assist individuals with compliance. In addition, 10 states reported that a total of \$28 million was appropriated in state fiscal year 2007, and 15 states budgeted funds for implementation costs in state fiscal year 2008. Despite these measures, states reported that the requirement has increased the level of assistance needed by individuals and amount of time spent by states during the enrollment process. States specified two aspects of the requirement as increasing the burden for them and for individuals: that documents had to be originals and the list of acceptable documents was complex and did not allow for exceptions. Further, although CMS estimated the requirement would result in savings for the federal government and states of \$90 million for fiscal year 2008, states' responses indicated that this estimate may be overstated for two reasons. Specifically, CMS did not account for the increased administrative expenditures reported by states, and the agency's estimated savings from ineligible, noncitizens no longer receiving benefits may be less than anticipated.

In commenting on a draft of the report, CMS raised concerns about the conclusions drawn from the survey responses as to the requirement's effect on access, mainly that states did not submit data to support their responses.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
DRA	Deficit Reduction Act of 2005
FMAP	Federal Medical Assistance Percentage
HHS	Department of Health and Human Services
OIG	Office of Inspector General
SSA	Social Security Administration
TRHCA	Tax Relief and Health Care Act of 2006

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United States Government Accountability Office
Washington, DC 20548

June 28, 2007

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
House of Representatives

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
House of Representatives

In recent years, states have focused on efforts to streamline and simplify the application and eligibility determination processes for Medicaid, the joint federal-state health care financing program that in fiscal year 2004 covered nearly 60 million low-income individuals, including children, families, and individuals who are elderly or disabled. For example, many states have made application and enrollment processes more accessible through mail-in applications. Some states have also simplified application processes by minimizing documentation requirements, permitting self-declaration of income, and automating systems. These streamlined processes were part of an effort to increase enrollment of eligible individuals in the program.

The Deficit Reduction Act of 2005 (DRA), which was enacted on February 8, 2006, contains many changes to Medicaid requirements, at least one of which affects states' abilities to streamline certain program operations.¹ Specifically, in addition to changes related to benefits, cost-sharing, provider payment, and program integrity, the DRA includes a provision that requires states to obtain satisfactory documentary evidence of U.S. citizenship or nationality² for nearly 40 million nonexempt Medicaid beneficiaries within 1 year of the provision's July 1, 2006,

¹DRA, Pub. L. No. 109-171, 120 Stat. 4 (2006).

²For the purposes of qualifying for Medicaid as a U.S. citizen, the United States is defined as the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as U.S. citizens for purposes of Medicaid. In this report, we combine references to the requirements to document U.S. citizenship or nationality under the broader rubric of documenting citizenship.

effective date, as well as for new applicants to the program, who constitute an estimated 10 million individuals annually.³ While U.S. citizenship or satisfactory immigration status has long been a requirement for Medicaid eligibility, individuals in most states could previously attest, under penalty of perjury, to their citizenship status in writing. Self-attestation of citizenship is no longer acceptable.⁴ Instead, the DRA requires that states implement an effective process for documenting citizenship in order to obtain federal Medicaid matching funds. Although the DRA did not provide any additional federal funds for costs associated with complying with this requirement, states may seek federal matching funds for such administrative expenditures. In implementing the DRA provision, the Centers for Medicare & Medicaid Services (CMS)⁵ issued an interim final rule that outlines a prescriptive process states must follow to obtain satisfactory documentation of citizenship for Medicaid applicants and existing beneficiaries and identifies a list of acceptable documentation.⁶ Five months after the DRA provision took effect, the Tax Relief and Health Care Act of 2006 was enacted, which exempted additional populations from documenting citizenship, such as children in foster care.⁷

³DRA, Pub. L. No. 109-171, § 6036, 120 Stat. 80-81 (to be codified at 42 U.S.C. §1396b). The DRA exempted certain groups of individuals, including individuals entitled to or enrolled in Medicare and certain Supplemental Security Income beneficiaries, from documenting citizenship.

⁴In a July 2005 report regarding states' oversight of the self-declaration of U.S. citizenship, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) identified 47 states that allowed self-attestation of citizenship for U.S. citizens and nationals. However, the HHS OIG reported that nearly all of these states had a written or informal "prudent person policy," which required individuals to submit documentary evidence when eligibility staff questioned the validity of their attestations. The remaining 4 states independently required U.S. citizens and nationals to provide documentary evidence of their citizenship status in order to qualify for their state Medicaid programs. HHS, OIG, *Self-Declaration of U.S. Citizenship for Medicaid* (July 2005).

⁵CMS is the agency within HHS responsible for administering the Medicaid program, including oversight of the citizenship documentation requirement.

⁶*Medicaid Program; Citizenship Documentation Requirements*, 71 Fed. Reg. 39,214 (July 12, 2006). For the purposes of this report, we refer to the requirement to document citizenship in the DRA and the related requirements identified in the implementing federal regulations as "the requirement."

⁷Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, title IV, §405(c), 120 stat. 2922, 2998-2999 (2006) (to be codified at 42 U.S.C. §1396b(x)(2)).

Interested parties, including states and advocacy organizations, have raised concerns about the requirement, such as stating that the need for the requirement had not been established,⁸ that efforts to comply with the requirement will result in eligible citizens losing access to Medicaid coverage, and that it will be costly for states and individuals. You asked us to evaluate the effect of the requirement on eligible individuals' access to the Medicaid program and the administrative and fiscal burden the requirement imposed on individuals, states, and the federal government. For this report, we (1) examined how the requirement has affected individuals' access to Medicaid benefits and (2) assessed the administrative and fiscal effects of implementing the requirement.

To conduct our work, we surveyed state Medicaid offices in the 50 states and the District of Columbia about the effects of the requirement and obtained responses from 96 percent of them (49 of 51).⁹ Of the 49 responses, 1 state's response was largely incomplete and 4 states reported they had not implemented the requirement as of January 2007,¹⁰ so we excluded those 5 states from our analysis, leaving 44 usable responses.¹¹ States submitted responses in March and April 2007. With regard to the effects on individuals' access to Medicaid benefits, we asked states for their perspectives about (1) changes in enrollment as a result of the requirement, (2) the reasons for any enrollment declines,¹² (3) the groups

⁸Specifically, in response to the July 2005 report by the OIG of HHS regarding states' oversight of the self-declaration of U.S. citizenship, CMS acknowledged that the OIG did not find problems regarding false allegations of citizenship and further noted that CMS was not aware of any such problems.

⁹Throughout this report, the term "state" refers to the 50 states and the District of Columbia.

¹⁰Three of the 4 states reported taking steps to implement the requirement, such as conducting data matches for existing beneficiaries, but, for example, were awaiting issuance of state regulations before fully implementing. The remaining state reported that it implemented the requirement in April 2007. As of May 2007, CMS was aware that not all states had fully implemented the requirement.

¹¹These 44 states accounted for 71 percent of national Medicaid enrollment in fiscal year 2004, the most recent year that CMS data are available. The 2 states not responding to the survey represented 5 percent of Medicaid enrollment in fiscal year 2004, and the 5 states excluded from our analysis constituted the remaining 23 percent.

¹²In the survey, we asked states whether they thought enrollment declines were due, in part, to individuals who appeared to be eligible citizens experiencing delays or losses in Medicaid coverage. We believed that states' assessments of individuals' citizenship were appropriate given their reliance on prudent person policies to make such determinations under their prior self-attestation policies.

most affected, and (4) expectations of how long reported changes would continue. We also asked about state policies regarding the amount of time states allow individuals to comply with the requirement before denying coverage or terminating enrollment. With regard to the administrative and fiscal effects of the requirement, we asked states about (1) measures taken to implement the requirement and assist individuals with compliance, (2) changes in the number of individuals needing assistance during the eligibility determination process and the amount of time necessary for states to make eligibility determinations after implementing the requirement, (3) the average number of pending and completed eligibility determinations before and after implementing the requirement, (4) the challenges they and individuals faced in meeting the requirement, and (5) the budget implications of the requirement in state fiscal years 2007 through 2010.¹³ We did not independently validate the trends or the data states provided. The results of our survey represent only the views of the 44 state Medicaid offices that completed it.

In assessing the administrative and fiscal effects of the requirement, we also reviewed federal laws, regulations, and CMS guidance to states related to the requirement, and compared the requirement with citizenship documentation requirements applied by other federal agencies, including the Social Security Administration (SSA). In addition, we interviewed CMS officials regarding certain aspects of the requirement. We also obtained CMS's estimates of the administrative and fiscal effects of the requirement on states and the federal government. We performed our work from November 2006 through June 2007 in accordance with generally accepted government auditing standards.

Results in Brief

States reported that the requirement resulted in barriers to access to Medicaid, such as delayed or lost coverage for some eligible individuals. Twenty-two of the 44 states reported declines in Medicaid enrollment due to the requirement, and a majority of these states attributed the enrollment declines to delays in or losses of Medicaid coverage for individuals who appeared to be eligible citizens. Of the remaining states, 12 reported that the requirement had no effect on enrollment, and 10 reported that they did not know the effect of the requirement on enrollment. Not all of the

¹³States define their fiscal years differently. For example, some states' fiscal years are the same as the federal fiscal year (October 1 through September 30), while in other states, the fiscal year runs from July 1 to June 30.

22 states reporting enrollment declines as a result of the requirement could quantify the decline. One that had begun tracking the effect, however, identified 18,000 individuals in the first 7 months of implementing the requirement whose applications were denied or who had coverage terminated due to the inability to provide the necessary documentation, though the state generally believed them to be eligible citizens. States that reported a decline in enrollment varied in their impressions of the effects of the requirement on enrollment beyond the first year of implementation. The effect of the requirement on individuals' access to Medicaid could have been influenced by state enrollment policies and whether an individual was an applicant or an existing beneficiary. For example, states that relied primarily on mail-in applications prior to implementing the requirement were more likely to report declines in enrollment than were states where individuals most frequently applied in person. In addition, the requirement may affect Medicaid applicants more adversely than beneficiaries because applicants in some states were given less time to comply and were not eligible for Medicaid benefits until they documented their citizenship.

Although states have invested resources to implement the requirement, potential fiscal benefits for the federal government and states are uncertain. All of the 44 states reported taking a number of administrative measures, such as training eligibility workers and hiring additional staff, to implement the requirement and assist individuals with compliance. In addition, 10 states reported that a total of \$28 million was appropriated for the requirement in state fiscal year 2007, and 15 states budgeted funds for state fiscal year 2008. Despite these measures, states reported that the requirement resulted in the state spending more time completing applications and redeterminations and individuals needing more assistance in person during the process. States reported that two aspects of the requirement increased the burden of the requirement on individuals and states, namely (1) that documents must be originals and (2) the list of acceptable documents was complex and did not allow for exceptions. For example, states reported that individuals who previously would have applied for Medicaid through the mail will not part with original documents, such as driver's licenses, and are instead presenting them in person, which has increased the workload of states' eligibility workers. CMS officials noted, however, that the agency took a number of steps to minimize the administrative burden of the requirement, including substantially expanding the list of acceptable documentation beyond what was included in the DRA provision. In addition to the ongoing challenges to states and individuals, federal estimates of the financial benefits of the requirement for the federal government and states may be overstated.

CMS estimated the requirement would result in savings of \$50 million for the federal government and \$40 million for states in fiscal year 2008 as a result of terminations of eligibility for noncitizens inappropriately receiving Medicaid benefits. State responses indicated, however, that CMS's estimate of savings may be overstated because the estimate did not account for the increases in administrative expenditures reported by states and the intended effect of the requirement—to prevent ineligible noncitizens from receiving Medicaid benefits—may be less prevalent than CMS expected. For example, among the states that reported expecting the requirement to result in a decrease in Medicaid expenditures, only one state reported potential savings as a result of individuals being denied or terminated from coverage who were determined ineligible because of their citizenship status.

In commenting on a draft of this report, CMS raised concerns about the sufficiency of the underlying data and made several comments about our findings on the administrative and fiscal effects of the requirement. In particular, CMS expressed concern that the report overstated the significance of states' reports of declines in enrollment due to the requirement and the challenges that states and individuals faced in complying with it. CMS nevertheless agreed the requirement posed challenges for individuals and states, though the agency stated that it believed these challenges had decreased and would continue to do so. Our findings represent the views of state Medicaid offices, which stated that the requirement has resulted in enrollment declines and has posed administrative burdens to states and individuals. Further, our survey results indicate that the effects states experienced in the first year may continue at least to some extent in the future.

Background

Medicaid programs generally represent an open-ended entitlement under which the federal government is obligated to pay its share of expenditures for covered services provided to eligible individuals under each state's federally approved Medicaid plan.¹⁴ Under federal Medicaid law, to qualify for Medicaid coverage, individuals generally must fall within certain eligibility categories—such as children, pregnant women, adults in

¹⁴Under a statutory formula, the federal government may pay from 50 to 83 percent of a state's Medicaid expenditures, known as the Federal Medical Assistance Percentage (FMAP). States with lower per capita incomes receive higher FMAP matching rates. The FMAP for administrative costs is the same for all states and is generally 50 percent for administrative costs. 42 U.S.C. §§ 1396b(a), 1396d(b).

families with dependent children, and those who are aged or disabled—and meet financial eligibility criteria.¹⁵ In addition, since 1986, federal law has required that, as a condition of Medicaid eligibility, individuals declare under penalty of perjury that they are citizens or nationals of the United States or in satisfactory immigration status.¹⁶ Eligibility is determined at the time of application, and for individuals enrolled in the program, at a regular basis referred to as redetermination.¹⁷

States differ in how they determine eligibility for Medicaid, and many took steps before 2006 to streamline their enrollment processes. While some states conduct all eligibility screening and determinations within the state's Medicaid agency, other states contract with different state agencies, counties, or other local governmental entities to conduct or assist with eligibility determinations. In some cases, states also utilize community-based organizations to assist with outreach and education in their Medicaid programs. Over the past decade, states have also made efforts to simplify the application process to make Medicaid programs more accessible to eligible families. As part of these efforts, many states implemented mail-in applications and ended requirements for face-to-face interviews. States also began coordinating Medicaid eligibility determinations with other public programs, such as school lunch programs and Temporary Assistance for Needy Families.

Enacted in February 2006, the DRA includes a number of new requirements for state Medicaid programs.¹⁸ Most relevant to this report, as of July 1, 2006, the DRA required states to document citizenship of applicants and beneficiaries as a condition of receiving federal matching

¹⁵See 42 U.S.C. § 1396a(a)(10).

¹⁶Immigration Reform and Control Act of 1986, Pub. L. No. 99-603, § 121, 100 Stat. 3359, 3384-3391 (1986) (codified, as amended, at 42 U.S.C. § 1320b-7). Under this law, individuals who declared themselves aliens in satisfactory immigration status were required to present specific documentary evidence of their status, while those who declared themselves citizens were not. Individuals in satisfactory immigration status include aliens who are lawful permanent residents, refugees, and other aliens under special circumstances.

¹⁷Federal Medicaid regulations require states to redetermine the eligibility of a Medicaid beneficiary at least once every 12 months or more frequently if the state receives information that may affect the eligibility of the Medicaid beneficiary. 42 C.F.R. 435.916.

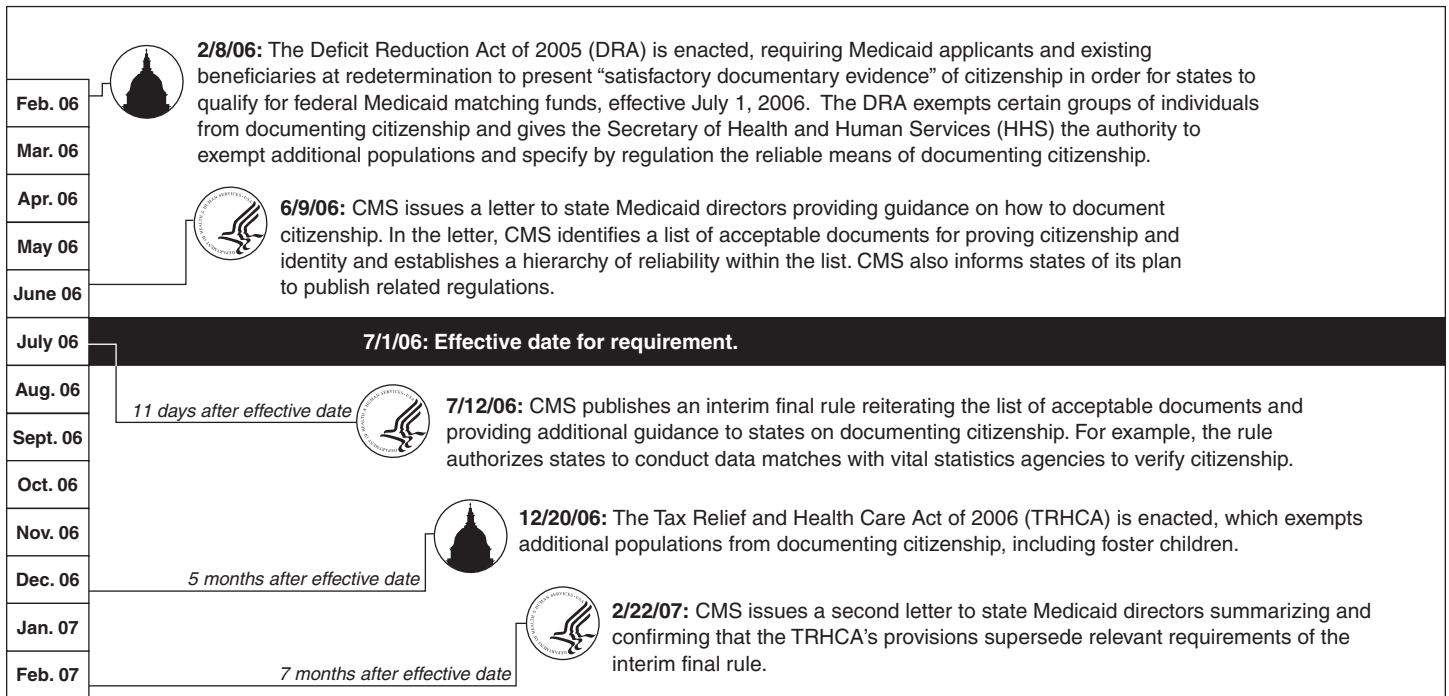
¹⁸For example, the DRA provided states with the ability, under a State Plan Amendment, to restructure Medicaid benefit packages based on newly defined criteria and to impose varying levels of cost-sharing for certain Medicaid populations. See DRA, Pub. L. No. 109-171, §§ 6041-6044, 120 Stat. 81-92 (2006) (to be codified at 42 U.S.C. §§ 1396o-1, 1396u-7).

funds for their Medicaid expenditures.¹⁹ Under this provision, Medicaid applicants and beneficiaries who are undergoing redeterminations of eligibility must provide “satisfactory documentary evidence” of citizenship.²⁰ Documenting citizenship is a onetime event completed by individuals either at application or, for those already enrolled, at their first redetermination of eligibility. (Fig. 1 illustrates the sequence of key events regarding the requirement from enactment of the DRA through February 2007.)

¹⁹DRA, Pub. L. No. 109-171, § 6036, 120 Stat. 80-81 (2006) (to be codified at 42 U.S.C. § 1396b). The DRA, however, did not impose any additional requirements for Medicaid applicants and beneficiaries who declare themselves aliens in satisfactory immigration status.

²⁰“Satisfactory documentary evidence” is defined as a list of specific documents, such as a U.S. passport, and includes those documents that the Secretary of HHS determines, under federal regulations, to provide proof of citizenship and a reliable means of identification.

Figure 1: Key Events in the Implementation of the Requirement



Source: GAO.

The DRA explicitly exempts certain individuals from having to document citizenship, specifically those entitled to or enrolled in Medicare, certain individuals receiving Supplemental Security Income, and any additional populations as designated by the Secretary of HHS.²¹ In December 2006, Congress expanded the list of populations that are exempt, adding individuals receiving Social Security disability insurance benefits and children in foster care or children who are receiving adoption or foster care assistance.²²

In implementing the DRA provision, CMS first provided guidance to states in a June 2006 letter to state Medicaid directors and subsequently published an interim final rule on July 12, 2006, almost 2 weeks after the

²¹The DRA permits such a designation only when the Secretary of HHS finds that satisfactory documentary evidence of citizenship had been previously presented.

²²See Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432, title IV, § 405(c), 120 Stat. 2922, 2998-2999 (2006) (to be codified at 42 U.S.C. § 1396b(x)(2)).

DRA provision went into effect.²³ In the interim final rule, CMS expanded upon the list of acceptable documents identified in the DRA and published regulations that grouped the documents by level of reliability, creating a hierarchy in the list and restricting the use of less reliable documents.

As required under the DRA, certain documents, such as U.S. passports, are considered sufficient evidence of citizenship. The DRA requires that if an individual does not have one of these primary documents, the individual must produce specific types of documentation establishing citizenship, such as a U.S. birth certificate, as well as documentation establishing personal identity. The regulations published by CMS similarly identify primary, or tier 1, documents to establish citizenship. Under the regulations, if individuals do not have primary evidence, they are expected to produce secondary, or tier 2, evidence of citizenship, such as a military record showing a U.S. place of birth, as well as evidence of identity, such as a state-issued driver's license. If neither primary nor secondary evidence of citizenship is available, individuals may provide third tier evidence of citizenship to accompany evidence of identity. If primary evidence of citizenship is unavailable, secondary and third tier evidence do not exist or cannot be obtained in a reasonable time period, and the individual was born in the United States, then the individual may provide fourth tier evidence of citizenship, along with evidence of identity. (See table 1 and app. I.)

²³As of June 2007, CMS indicated that a final rule is forthcoming.

Table 1: Examples from the List of Acceptable Documents for Proving Citizenship Defined under Federal Regulations, by Level of Reliability

Level of documentation	Examples of acceptable documents	Other documents required
Tier 1 (most reliable)	<ul style="list-style-type: none"> • U.S. passport^a • Certificate of naturalization^a • Certificate of citizenship^a 	None
Tier 2	<ul style="list-style-type: none"> • U.S. birth certificate^b • Report of birth abroad of a U.S. citizen^b • U.S. citizen I.D. card issued by the Immigration and Naturalization Service^b • Final adoption decree showing the child’s name and U.S. birthplace • U.S. military record showing U.S. place of birth 	Verification of identity ^c
Tier 3	<ul style="list-style-type: none"> • Hospital record showing a U.S. place of birth • Health insurance record showing a U.S. place of birth 	Verification of identity ^c
Tier 4 (least reliable)	<ul style="list-style-type: none"> • Federal or state census record showing U.S. citizenship or place of birth • Nursing home admission papers showing a U.S. place of birth • U.S. vital statistics official notice of birth registration 	Verification of identity ^c

Source: GAO analysis of the DRA and regulations published by CMS.

Notes: This table is not a comprehensive list of documents CMS considers reliable evidence of citizenship. Further, the table does not detail CMS’s restrictions for using particular documents. For example, in tier 2, a U.S. birth certificate must be issued before the individual turned 5 years of age. In tier 3, hospital records must be on hospital letterhead and created at least 5 years before the date of the individual’s application for Medicaid. Appendix I provides a more complete list of documents and accompanying restrictions as well as a list of acceptable documents for verifying identity.

^aUnder the DRA, this document was determined to be satisfactory evidence of citizenship.

^bUnder the DRA, this document was determined to be satisfactory evidence of citizenship when accompanied by documentation of identity.

^cAcceptable evidence of identity includes such documents as driver’s licenses, school identification cards, and, for children under 16, school records.

In addition to prescribing a list of acceptable documents for verifying citizenship, the regulations issued by CMS specify, with one exception, that documents must be originals or copies certified by the issuing agency. The exception is that for a U.S. birth certificate, which is a tier 2 document, states may use a cross match with a state vital statistics agency to document a birth record. The regulations allow states to accept original documentation from individuals in person or through the mail.

Under the regulations issued by CMS, states must provide applicants and Medicaid beneficiaries a “reasonable opportunity” to document their citizenship before denying or terminating Medicaid eligibility. States have flexibility in defining the length of the reasonable opportunity period. The

regulations further explain that current Medicaid beneficiaries must remain eligible for benefits during this period but that states may terminate eligibility afterward if they determine that the beneficiary has not made a good faith effort to present documentation. In contrast, applicants are not eligible for Medicaid coverage until they submit the required documentation. The regulations also require states to assist individuals who are physically or mentally incapable of obtaining documentation and do not have a representative to assist them. However, the regulations do not specify criteria for determining who is capable or the level of assistance states should provide. CMS intends to monitor state implementation of the requirement, including the extent to which states use the most reliable evidence available to establish citizenship based on its hierarchy. States that do not comply with the regulations may face either denied or deferred payment of federal matching funds.

In the interim final rule, CMS assessed potential administrative and fiscal effects of the requirement. For example, CMS estimated that individuals would need, on average, 10 minutes to acquire and provide the state with acceptable documentary evidence and that states would need 5 minutes per individual to verify citizenship and maintain current records.²⁴ In addition, CMS determined that implementing the rule would have no consequential effect on costs for state, local, or tribal governments or the private sector.²⁵ Under the rule, states may seek federal Medicaid matching funds for administrative expenditures associated with implementing the requirement at a 50 percent federal matching rate.

²⁴In order to meet its obligations under the Paperwork Reduction Act of 1995, CMS solicited comments on these estimates.

²⁵CMS did not perform a detailed analysis of the costs and benefits prior to issuing this rule, as would otherwise be required under the Unfunded Mandates Reform Act of 1995, because it determined that the cost would be less than \$100 million (or approximately \$120 million in 2006 dollars) for any 1 year.

Many States Reported That the Requirement Resulted in Delayed or Lost Medicaid Coverage for Some Individuals Who Appeared to Be Eligible

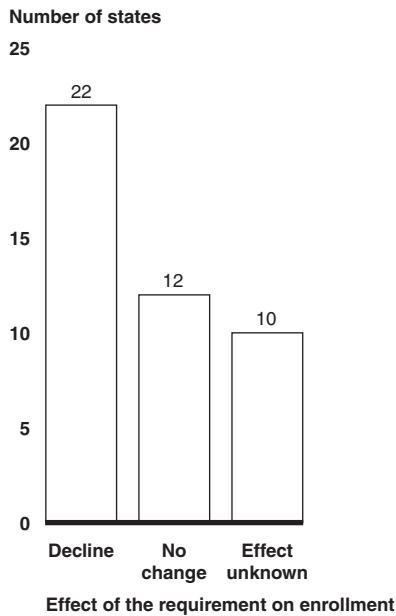
States reported that the requirement resulted in barriers to access, such as delayed or lost Medicaid coverage for some eligible individuals. Of the 44 states, 22 reported a decline in Medicaid enrollment due to the requirement. Most that reported a decline in enrollment attributed it to delays in or losses of coverage for individuals who appeared to be eligible citizens, and all states reporting a decline reported that children were affected by the requirement. States that reported a decline in enrollment varied in their views of the effects on access to Medicaid coverage after the first year of implementation. State enrollment policies and whether an individual is an applicant or a beneficiary at redetermination are two factors that may have influenced the effect of the requirement on individuals' access.

States Reported Enrollment Declines Largely Driven by Delays in or Losses of Medicaid Coverage for Eligible Citizens

Half the states that reported implementing the requirement noted that the requirement resulted in declines in Medicaid enrollment.²⁶ Of the 44 states, 22 states reported a decline in enrollment due to implementing the requirement, 12 reported no change in enrollment as a result of the requirement, and 10 reported that they did not know the effect of the requirement on enrollment (see fig. 1). Of the 22 states that reported a decline in enrollment due to the requirement, all responded that children were affected by the requirement, and 21 reported that adults were affected, with 2 specifying pregnant women. A few also responded that the aged and blind and disabled were also affected.

²⁶Of the 44 states, all reported implementing the requirement as of January 2007: 33 implemented the requirement in July 2006, the month that the requirement became effective, 8 did so within the 2 months following, and 3 did so within 6 months of the July 1, 2006, effective date.

Figure 2: Effect of the Requirement on Medicaid Enrollment, as Reported by States



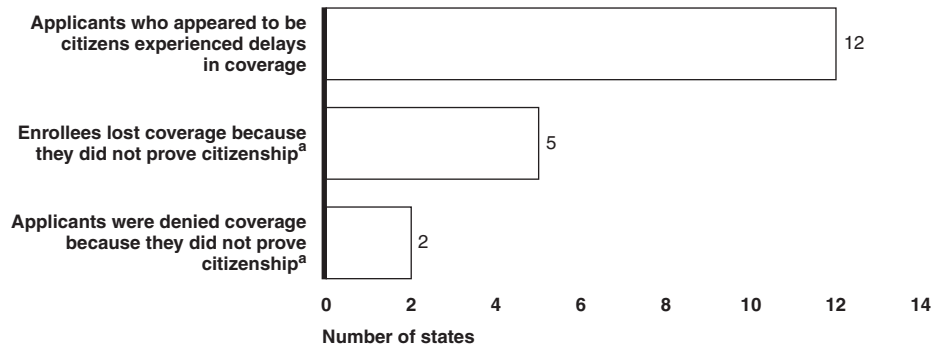
Source: GAO survey of state Medicaid offices.

Note: Numbers reflect responses from 44 states.

Though states often cited a combination of reasons for the decline in Medicaid enrollment, when asked the primary reason, the majority of states (12 of 22) reported that enrollment declined because applicants who appeared to be eligible citizens experienced delays in receiving coverage. In addition, 5 of the 22 states identified the primary reason for the enrollment decline as current beneficiaries losing coverage, with 4 of the 5 states reporting that those individuals appeared eligible. Two states reported that declines were largely driven by denials in coverage for individuals who did not prove their citizenship. It was unclear from survey results, however, whether these individuals were determined ineligible because they were not citizens or simply because they did not provide the required documents within the time frames allowed by the state. (See fig. 3.) Two of the remaining 3 states reported that the primary reason for the decline was that individuals were discouraged from applying because

of the requirement or were not responding to states' requests for documentation of citizenship.²⁷

Figure 3: Primary Reason Why Requirement Resulted in Medicaid Enrollment Declines, as Reported by States



Source: GAO survey of state Medicaid offices.

Notes: Numbers do not sum to 22, the number of states reporting a decline in Medicaid enrollment as a result of implementing the requirement, because 2 states reported other reasons, namely that individuals were discouraged from applying or were not responding to states' requests for the documentation, and 1 state did not answer the relevant survey question.

^aIt is unclear from the survey results whether these individuals lost or were denied coverage because they were not citizens or because they did not provide the required documentation.

The extent of the decline in Medicaid enrollment due to the requirement in some individual states or nationally was unknown because not all states track the effect of the requirement on enrollment. However, 1 state that had begun tracking the effect reported (1) denying an average of 15.6 percent of its monthly applications because of insufficient citizenship documentation in the first 7 months following implementation and (2) terminating eligibility for an average of 3.2 percent of beneficiaries at redetermination per month over the same period and for the same reason. Overall, these denials and terminations represented over 18,000 individuals, who the state generally believed were eligible citizens.²⁸ While not tracking the effect of the requirement on enrollment explicitly, 10 other states that attributed enrollment declines at least in part to applicants who were delayed or denied coverage also reported increases

²⁷The last state did not answer the survey question about the reasons that the requirement led to a decline in enrollment.

²⁸This state's total Medicaid enrollment was about 970,000 in fiscal year 2004, the most recent year of enrollment data available.

in monthly denials ranging from 1 to 14 percent after implementing the requirement.

States reporting a decline in Medicaid enrollment differed in their views of the effects of the requirement on enrollment after the first year of implementation. Of the 22 states that reported a decline in enrollment, 17 states responded that they expected the downward enrollment trend to continue. Five of these states indicated that the declines would level off within approximately 1 year of implementation, citing, for example, a drop-off in terminations once their current beneficiaries have successfully documented their citizenship. Ten of the 17 states reported that they were unsure how long enrollment declines would continue or generally expected the trend to continue indefinitely.²⁹ A few of these states noted concern about the ongoing effect on new applicants who will be unfamiliar with the requirement and may be denied enrollment or discouraged from applying. The remaining 5 of 22 states reported that they did not expect the decline to continue.³⁰

State Enrollment Policies and Individuals' Enrollment Status May Have Influenced Effect of Requirement on Access to Medicaid

Variation in the effects of the requirement on individuals' access may have resulted from different state enrollment policies. For example, states that reported a previous reliance on mail-in applications and redeterminations were more likely to report a decline in Medicaid enrollment. About two-thirds of the 22 states that reported a decline in enrollment indicated that individuals most commonly applied by mail before the requirement was implemented. In contrast, the majority of the 12 states that reported no change in enrollment reported that individuals most frequently applied in person before the requirement was implemented. In addition, prior to implementation, 6 states had documentation policies in place that were similar to the requirement. Three of these 6 states reported no change in enrollment, with 1 explaining that it was because the state already required (1) proof of birth to verify age and family relationship and

²⁹The remaining 2 states did not indicate how long the trend would continue.

³⁰Of these 5 states, 2 noted that they had already documented citizenship for current Medicaid beneficiaries; 1 reported that it accepts photocopies of acceptable documentation; and the remaining 2 expected people eventually to provide the necessary documents and qualify for Medicaid.

(2) proof of identity for adults. Two of the 6 states reported a decline in enrollment caused by the requirement.³¹

Another enrollment policy that may have influenced the requirement's effect on access to Medicaid coverage was the amount of time states allowed individuals to comply with the requirement—otherwise known as reasonable opportunity periods. In total, 33 states reported the number of days they allowed applicants and beneficiaries to meet the requirement before denying applications or terminating eligibility, with limits generally ranging from 10 days to 1 year. Nine of the 33 states reported allowing applicants 30 days or less, and 4 of these states also reported a decline in enrollment due to the requirement.³² A few states reported allowing applicants and beneficiaries an indefinite amount of time to obtain and submit the necessary documentation, provided they were deemed as making a good faith effort. Some states' written policies indicated that the reasonable opportunity period could be extended, provided the individual notified the state that he or she was making a good faith effort to obtain the documentation but needed more time.³³

The effect of the requirement on access may have also depended on whether the individual was a new applicant or a beneficiary at redetermination. Applicants who declare themselves citizens are not eligible for Medicaid coverage until they submit the required documentation, while beneficiaries at redetermination maintain their eligibility while collecting documents as long as they are within the reasonable opportunity period allowed by the state or deemed as making a good faith effort to comply with the requirement. For example, a pregnant woman at redetermination is eligible to have her 20-week ultrasound covered by Medicaid, even though she has not yet submitted her documentation to the state. In contrast, a pregnant woman who is a new Medicaid applicant would not be determined eligible for coverage until she

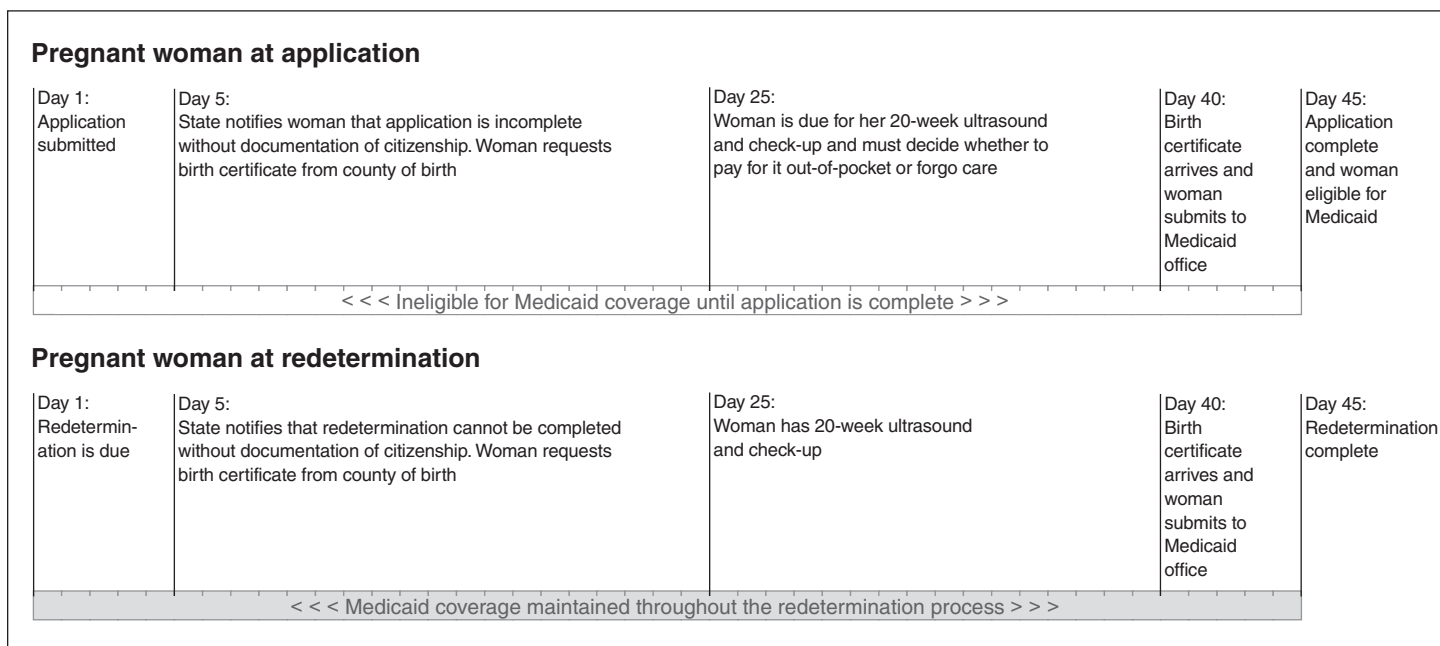
³¹The sixth state responded that it did not know the effects of the requirement on enrollment.

³²Of the 5 remaining states, 3 reported they did not know the effect of the requirement on enrollment, and 2 reported the requirement had no effect on enrollment.

³³However, states did not define what is considered a good faith effort.

submits her documentation (see fig. 4).³⁴ In addition, applicants who were born out of state may have faced additional delays while attempting to obtain documentation from their birth state. For example, one state noted that it could take 6 months or more to obtain a birth certificate from another state.

Figure 4: Comparison of the Effect of the Requirement on a Pregnant Woman Applying for Medicaid and a Pregnant Woman at Redetermination



Source: GAO.

In addition, applicants in some states were given less time than beneficiaries to meet the requirement. Of the 33 states that provided information on their reasonable opportunity periods, 13 states reported that the time allowed for providing documentation was longer for beneficiaries at redetermination than for applicants, with this difference ranging from 24 to 320 days. Five of the 13 states reported allowing

³⁴If the applicant is determined eligible, she generally would qualify for Medicaid 3 months prior to the date of her application if she met eligibility requirements during that period. Accordingly, she can be reimbursed for the cost of an ultrasound provided during the retroactive coverage period, but she may first be required to pay the full out-of-pocket cost at the time of service, which many Medicaid-eligible individuals may find difficult to afford.

45 days for applicants and 300 days or more for beneficiaries. States may offer more flexibility to Medicaid beneficiaries as CMS officials told us that for these individuals the state cannot terminate benefits without documenting that the beneficiary has not made a good faith effort to provide the necessary documentation.

States Reported Investing Resources to Implement Requirement, with Fiscal Benefits Uncertain

Although states reported investing resources to implement the requirement, potential fiscal benefits for the federal government and states are uncertain. To implement the requirement and assist individuals with compliance, all of the 44 states took a number of administrative measures, such as providing additional training for eligibility workers and hiring additional staff, and some also reported committing financial resources. Despite these measures, however, states reported that as a result of the requirement, individuals needed more assistance in person and it was taking the state longer on average to complete applications and redeterminations. According to states, two particular aspects of the requirement increased the burden of implementing it: (1) that documents must be originals and (2) the list of acceptable documents was complex and did not allow for exceptions. While CMS estimated federal and state savings from the requirement, the estimates may be overstated.

State Resources Invested to Implement the Requirement and Assist Individuals with Compliance

All 44 states reported taking a number of administrative measures to implement the requirement and assist individuals with compliance. Measures most frequently taken by states included training eligibility workers, revising application and redetermination forms, conducting vital statistics data matches, and modifying information technology systems. For example, 1 state reported that in addition to training 18,000 staff on the requirement, it also provided training and information to community agencies, consumer advocates, and providers on how to assist individuals with compliance. Another state established data matches with Indian Health Services to obtain hospital records that met the requirement and built a Web site on which eligibility workers could search the state's vital records to document citizenship. To supplement the efforts of eligibility workers, 3 states reported having formed special units of staff focused entirely on assisting individuals to meet the requirement, particularly in difficult cases where eligibility workers had been unsuccessful in their attempts to help individuals comply. One of those states reported that it was in the process of expanding the size of its team from 22 workers to 40 workers. Table 2 lists the administrative measures frequently reported by states.

Table 2: Administrative Measures Frequently Taken by States to Implement the Requirement and Assist Individuals with Compliance

Measures taken by states	Number of states (of 44)
Conducted additional training for eligibility workers	39
Revised application and redetermination forms	33
Conducted data matches with the state's vital statistics agency	33
Modified information technology systems	32
Conducted educational outreach to individuals	32
Assisted individuals in paying for documents	18
Hired or allocated additional staff	15
Authorized overtime pay	11
Added new application and redetermination methods	9
Increased third-party administrative contracts	7

Source: GAO survey of state Medicaid offices.

Beyond these administrative measures, 40 percent of the 44 states reported having appropriated funds for implementation or planned to do so in future years. Specifically, 12 states reported that funds were appropriated in their state fiscal year 2007 to implement the requirement, which for the 10 states that specified the amount totaled over \$28 million, with appropriations ranging from \$350,000 to \$10 million in individual states.³⁵ Further, 15 states budgeted funds for implementation costs in state fiscal year 2008.³⁶ While many states did not specifically appropriate funds toward implementing the requirement in state fiscal year 2007, this may have been due, in part, to the timing of the requirement within the budget year. States may not be budgeting funds for future years for various reasons, including that the burden of the requirement may decrease after the first year of implementation or that the state may face other budget constraints. For example, one state Medicaid office that reported a significant backlog in applications and redeterminations as a result of the requirement requested funds for implementation in state fiscal year 2008

³⁵In 2005, the most recent year of Medicaid expenditure data available from CMS, the 10 states' Medicaid administrative expenditures ranged from approximately \$22 million to over \$320 million. The amount of funds that states reported were appropriated to implement the requirement represented from 1 percent to 12 percent of each state's respective 2005 Medicaid administrative expenditures.

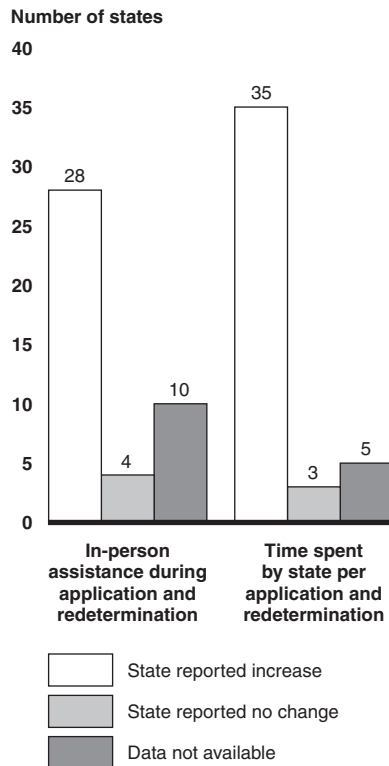
³⁶To the extent that states increase Medicaid administrative spending to implement the requirement, the federal government will share in the costs.

and planned to renew those requests in state fiscal years 2009 and 2010, but was not sure whether the state legislature would appropriate the funds.

Two Aspects of the Requirement Increased the Burden of Implementation

Despite investments of resources, most states reported that the requirement resulted in the state spending more time completing applications and redeterminations and individuals needing more assistance in person during the process. Of the 44 states, 28 states reported increases in the level of assistance provided to clients in person, and 35 states reported an increase in the amount of time it took the state to complete applications and redeterminations. (See fig. 5.) States reporting no change in the level of in-person assistance or time spent completing applications and redeterminations since implementation were frequently states where individuals primarily applied for and renewed Medicaid enrollment in person prior to the requirement.

Figure 5: Effect of the Requirement on States' Level of Assistance and Amount of Time Needed during Application and Redetermination



Source: GAO survey of state Medicaid offices.

Notes: Numbers do not sum to 44 for level of assistance, because 1 state reported that the amount of in-person assistance increased for applications but did not change for redeterminations and therefore was not counted, and another state did not answer the question related to assistance provided in person. For changes in time spent by the state per application and redetermination, numbers do not sum to 44 because 1 state did not answer the related question.

Of the 35 states that reported increases in enrollment processing time, most reported that the requirement added 5 or more minutes per case to the processing time for applications and redeterminations. While only 1 of the 35 states expected an increase of less than 5 minutes per case, 9 states estimated an additional 5 to 15 minutes per case, and 16 states expected the requirement to add over 15 minutes of processing time per application or redetermination, well above the 5 minutes estimated by CMS in the interim final rule.³⁷ One of these 16 states reported processing an average

³⁷The remaining states (9 of 35) did not specify the amount of additional state processing time resulting from the requirement.

of over 150,000 applications per month in the 8 months following implementation. In that state, assuming an increase in processing time of a minimum of 16 minutes per application since implementing the requirement, this would have added at least 40,000 hours of staff time per month. Other states emphasized that the effect of the requirement on workload goes beyond the amount of time necessary to complete applications and redeterminations. For example, one state reported a 60 percent increase in phone calls (from 24,000 to 39,000 per month), a tenfold increase in voice messages (from 1,200 to 11,000 per month), and an 11 percent increase in the amount of time spent on each call.³⁸

Though the requirement represented a change in enrollment procedures for most states, states reported that certain aspects of the requirement specified under federal regulations by CMS increased their implementation burden. More than 80 percent of states (36 of 44) reported facing administrative challenges in implementing the requirement, and many attributed the challenges to two specific aspects of the requirement outlined in the regulations, namely (1) that documents must be originals and (2) that the list of acceptable documentation was complex and did not allow for exceptions. In fact, nearly all states (42 of the 44) reported that having to provide original documentation posed a barrier to eligible citizens' meeting the requirement. Further, many states also reported that mandating originals affected state workload primarily because individuals did not feel comfortable mailing the documents to the state and instead began presenting them in person. With regard to the list of acceptable documents, states reported that the list was complex, often confusing both individuals and eligibility workers, and left states with no discretion to allow exceptions. For example, 1 state that documented citizenship for Medicaid prior to enactment of the DRA noted that when acceptable documentation was not available, the state made an assessment based on a preponderance of evidence, which included certain tribal documents excluded from CMS's list. Thirty-four states reported that an individual's inability to provide documents other than those defined under federal regulations by CMS created a barrier to individuals' compliance with the

³⁸After implementing the requirement, some states also observed increases in the number of pending applications per month and a decrease in the number of redeterminations completed per month, indicating larger caseloads for some eligibility workers. For example, 20 of the 26 states with data available on applications reported an increase in the number of pending applications per month after implementing the requirement, with just over half of states observing increases of at least 30 percent. In 3 states, this increase represented an additional 10,000 pending applications per month as compared to the average number of pending applications per month prior to implementing the requirement.

requirement. Table 3 presents some of the challenges reported by states to implement the requirement.

Table 3: Challenges Posed by Certain Aspects of the Requirement, as Reported by States

Aspect of requirement	Challenge posed	Description
Documents must be originals	Cost of obtaining original documents	Low-income families enrolled in Medicaid often cannot afford to pay for original documents such as birth certificates, which can cost up to \$30 each. When individuals are physically or mentally incapable of obtaining documents for themselves, doing so becomes the state's responsibility, the cost of which has raised concerns among several states.
	Original documents needed for daily living	Individuals cannot part with such documents as driver's licenses for the number of days it would take to mail them and have them returned by the state and do not want to risk identity theft. As a result, more individuals are submitting the documents in person, which has increased the volume of walk-in clients at eligibility offices. In some rural areas, individuals may have to travel significant distances to reach the nearest eligibility office to present the documents in person.
	Management and remittance of original documents	Some individuals are choosing to submit driver's licenses and U.S. passports through the mail, causing stress among eligibility workers who want to return the documents as quickly as possible. In addition, returning the documents can increase state mail costs.
Prescribed list of acceptable documents	Complexity of list	The complexity of the tiered list of acceptable documents has confused individuals and local eligibility workers. As a result, states have invested more time answering calls from customers and providing technical assistance to local offices.
	Lack of state discretion to allow exceptions	The list lacks flexibility for states to allow exceptions when an individual, or the state on the individual's behalf, cannot obtain any of the documents.

Source: GAO survey of state Medicaid offices.

When developing its interim final rule, CMS officials said that CMS considered the specifications of the DRA and other existing federal policies on documenting citizenship, including policies of SSA. CMS officials told us that after meeting the specifications of the DRA, the agency modeled its regulations after the policy established by SSA for documenting citizenship when individuals apply for a Social Security number. Specifically, SSA's policy mandates that documents be originals and includes a hierarchy of documents with restrictions on the use of less reliable documents. Also, the list of acceptable documents identified by CMS mirrors SSA's list with only a few exceptions. In contrast, however, SSA's policy allows more flexibility in special cases. For example, when a U.S.-born applicant for a Social Security number does not have any of the documents from the list, SSA's policy allows staff to work with their supervisors to determine what would be acceptable in those cases. CMS officials told us that CMS's list of acceptable documents represents a significant expansion of what was included in the DRA provision and is

exhaustive and that they were not aware of any case where an individual was unable to provide any document from the list.

To assist states and individuals in complying with documenting citizenship, CMS included some important tools in the regulations. For example, the regulations allow states to use data matches with state vital statistics agencies to verify citizenship and with other government agencies to verify identity, which could alleviate the need for individuals to submit original documents. While many states reported conducting data matches on behalf of individuals, several also expressed concerns that such matches required additional resources and could not be done for individuals born out of state. One state reported conducting 60,000 on-line inquiries per month into the state's vital records system after implementing the requirement. In one area of the state, however, nearly all children were born across state lines and therefore the state could not electronically verify their citizenship. The state reported that verifying citizenship for children in that portion of the state was especially difficult. While CMS officials confirmed that there is no nationwide database for verifying citizenship, they also told us that there are currently initiatives under way in more than one state to share vital statistics with other states through data matches.³⁹

Estimates of Federal and State Fiscal Benefits May Be Overstated

Though CMS expected some savings to result from the requirement in fiscal year 2008, the estimate did not account for the cost to states and the federal government to implement the requirement. CMS's Office of the Actuary estimated that the requirement would result in \$50 million in savings for the federal government and \$40 million in savings for states in fiscal year 2008, with all savings resulting from terminations of eligibility for individuals who were not citizens. Specifically, CMS assumed that 50,000 noncitizen beneficiaries (which represent less than 1 percent of Medicaid enrollment nationwide) would prove ineligible for Medicaid benefits and be terminated from the program. Though CMS authorized states to claim federal Medicaid matching funds for administrative expenditures related to implementing the requirement, and 15 states reported budgeting funds for 2008 in addition to the numerous other measures being taken by states, CMS's estimate of savings did not account

³⁹For example, according to CMS, the National Association for Public Health Statistics and Information Systems, an association of vital statistics agencies, is engaged in creating and making available a database and linking system to permit interstate electronic verification of vital statistics information.

for any increase in administrative expenditures by states or the federal government. CMS expected, however, that states would experience higher administrative costs during the first year of implementation with these costs decreasing in later years.

In addition to not accounting for the cost of the requirement, survey results indicated that CMS may have overestimated the potential savings from the requirement because the intended effect of the requirement, that is, to prevent ineligible noncitizens from receiving Medicaid benefits, may be less prevalent than expected. When asked about potential savings from the requirement, only 5 of the 44 states reported expecting the requirement to result in a decrease in their expenditures for Medicaid benefits in state fiscal year 2008, due in large part to individuals who appeared to be eligible citizens who experienced delays in or lost coverage. Only 1 of the 5 states expecting savings reported that enrollment declines resulted in part from denials or terminations of Medicaid coverage for individuals who were determined ineligible because of their citizenship status. The remaining 39 states expected no savings (20 states) or reported that it was too early to know (19 states). Several of the 20 states that expected no savings in 2008 reported that though some individuals have experienced delays in coverage, those individuals were eligible citizens and would eventually provide the required documentation and receive coverage. In addition, 2 of these 20 states noted that they were not inappropriately financing Medicaid benefits for noncitizens in the past and so expected no savings. Of the 19 states that were unsure how the requirement would affect expenditures, 2 were still tracking the effects of the requirement. Another of these 19 states—a state that reported a decline in enrollment as a result of implementing the requirement—reported that it was difficult to determine whether it would result in lower costs or whether costs would increase, as the state expected individuals would wait to enroll until they were ill or injured, rather than receive preventive care that is less costly to provide.

Agency Comments and Our Evaluation

We provided a draft of this report to CMS for comment and received a written response, which is included in this report as appendix II. CMS also provided technical corrections, which we incorporated as appropriate. CMS commented that it generally did not disagree with the approach of our study, but raised several concerns regarding the sufficiency of the underlying data for, and certain aspects of, our findings. In particular, CMS characterized the report's conclusions as overstating the effect of the requirement on enrollment, and stated it had concerns about the fact that the states did not submit data to substantiate their responses to the survey

questions on which we based our findings. CMS also commented on our findings related to the challenges posed by the requirement for states and individuals and the cost to states of implementing the requirement. Specific concerns raised and comments made by CMS, and our evaluation, follow.

Regarding the sufficiency of underlying data for certain findings, CMS commented that our survey asked states about the effects of the requirement on enrollment, although states did not provide data to validate their responses. In addition, CMS expressed concerns that the draft report appeared to draw broad conclusions about the effect of the requirement from data provided by one state. The purpose of our work was to report on the initial effects of the requirement. Absent national CMS data on the effects and because state Medicaid offices were largely responsible for implementing the requirement, we determined they were the best source for this information. Though not all states could quantify the effect of the requirement on enrollment, 22 states reported that the requirement resulted in decreases in enrollment, 12 reported that the requirement had no effect on enrollment, and 10 reported not knowing the effect of the requirement on enrollment. We disagree with CMS's assertion that the draft report drew broad conclusions about the effect of the requirement on enrollment from one state's data. The report clearly indicates that these data are from a single state and further notes that the extent of the decline in Medicaid enrollment due to the requirement in some individual states and nationally is unknown.

CMS raised concerns about one survey question that asked states that reported enrollment declines due to the requirement the reasons for those declines and also about the level of information provided regarding the degree to which the requirement deterred nonqualified aliens from applying for Medicaid. With regard to the first concern, in responding to our survey, states could check an option that said enrollment declines were caused by the delays in or losses of coverage for individuals who appeared eligible. CMS objected to the use of "appeared eligible," noting that the term is vague and subjective and that it tends to lead the respondent to certain conclusions. However, as we explain in the report, asking states to assess the citizenship status of individuals is consistent with most states' experience in making such determinations under the self-attestation policies that were in effect prior to the DRA provision. With regard to the second concern, we agree with CMS that our report provides limited information about the extent to which the requirement is deterring nonqualified aliens from applying for Medicaid. However, the report does discuss whether CMS had evidence that such individuals were falsely

declaring citizenship when applying for Medicaid. Specifically, our report notes that CMS in its comments to the 2005 OIG report on state self-attestation policies acknowledged that the OIG did not find problems regarding false allegations of citizenship, and CMS was not aware of any such problems.

CMS commented that the draft report overstated the effect of the requirement on enrollment because the majority of states reporting enrollment declines attributed the declines primarily to delays in receiving coverage rather than denials of coverage. Our report notes the implications for individuals of such delays in coverage. The report points out, for example, that a pregnant woman who is a citizen may be forced to forgo needed prenatal care while her coverage is delayed by efforts to meet the requirement. CMS also noted that its goal in implementing the requirement was to minimize the incidence of delays in or denials of eligibility due to the requirement.

In response to our findings that two aspects of the requirement specified under regulations issued by CMS—namely that documents be originals and that the list of acceptable documents is complex and does not allow for exceptions—presented challenges to states and individuals, CMS commented that the agency has attempted to provide as much flexibility as possible and that other federal agencies require original documentation. Nonetheless, our survey results clearly indicated that these two aspects of the requirement are viewed by most states as posing barriers to access. In particular, 42 of 44 states reported that having to provide original documentation posed a barrier to eligible citizens' meeting the requirement, and 34 states reported that an individual's inability to provide documents other than those defined under federal regulations by CMS created a barrier to compliance. Further, while the report explains that CMS modeled its regulations after SSA's policy for documenting citizenship when individuals apply for a Social Security number, the report also notes that, unlike CMS, SSA provides for flexibility in special cases.

CMS also commented on our finding that CMS's estimates of potential savings from the requirement in fiscal year 2008 did not account for administrative costs. Specifically, CMS agreed that its estimate did not account for administrative costs incurred by states to implement the requirement, but stated that any such costs would decrease after the first year of implementation. Our report describes that some states reported not having budgeted funds for the requirement in future years and explains that one reason for this may be that the burden of the requirement may decrease after the first year of implementation. However, the ongoing

costs of assisting applicants in complying with the requirement may continue to be significant for some states, especially those states that had to substantially modify their enrollment procedures. For example, as noted in the report, due to the requirement, one state faced an additional 40,000 hours of staff time needed per month to process applications.

CMS commented that it was not surprised that states reported facing challenges, given that the report's findings were based on states' experiences after less than 1 year of implementing the requirement. While agreeing that the requirement posed challenges for individuals and states, CMS asserted that these initial challenges have diminished and will continue to do so. Based on our survey responses, states largely do not share CMS's optimism in this regard. In addition to describing the initial effects of the requirement, which in states' perspectives have included enrollment declines and increased administrative burdens, our report includes additional indicators that the effects states experienced in the first year will continue at least to some extent in the future. For example, 17 of the 22 states that reported a decline in enrollment due to the requirement reported that they expected the downward trend in enrollment to continue, with some expecting the decline to continue indefinitely. In addition, 15 states reported already having budgeted funds for the requirement in state fiscal year 2008.

CMS also emphasized actions it has taken to implement the requirement, such as issuing a letter to state Medicaid directors, publishing an interim final rule, and working on a final rule to be issued shortly. Our report describes the steps taken by CMS to implement the requirement. With regard to CMS's work on a final rule, we modified our report to indicate CMS's plans to issue such a rule shortly.

As arranged with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies of this report to the Secretary of HHS, the Administrator of the Centers for Medicare & Medicaid Services, and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix III.

A handwritten signature in black ink, appearing to read 'James C. Cosgrove', written in a cursive style.

James C. Cosgrove
Director, Health Care

Appendix I: List of Acceptable Documents for Proving Citizenship and Identity, as Defined under Federal Regulations

Federal regulations published by the Centers for Medicare & Medicaid Services (CMS) identify primary, or tier 1, documents that are considered sufficient to establish citizenship. Under the regulations, if individuals do not have primary evidence, they are expected to produce secondary, or tier 2, evidence of citizenship as well as evidence of identity. If neither primary nor secondary evidence of citizenship is available, individuals may provide third tier evidence of citizenship with accompanying evidence of identity. If primary evidence of citizenship is unavailable, secondary and third tier evidence do not exist or cannot be obtained in a reasonable time period, and the individual was born in the United States, then the individual may provide fourth tier evidence of citizenship, along with evidence of identity. See table 4 for a list of acceptable documents to prove citizenship and table 5 for acceptable identity documents.

Table 4: List of Acceptable Documents for Proving Citizenship, as Defined under Federal Regulations

Level of documentation	Acceptable documents	Restrictions
Tier 1 (primary)	U.S. passport ^a	
	Certificate of naturalization ^a	
	Certificate of U.S. citizenship ^a	
	State-issued driver's license ^a	Limited to states that require proof of citizenship or that verified the individual's Social Security number as a condition of issuance
Tier 2 (secondary)	U.S. public birth certificate ^b	Certificate must have been issued before the individual was 5 years of age
	Certification of report of birth ^b	
	Report of birth abroad of a U.S. citizen ^b	
	Certification of birth issued by the Department of State ^b	
	U.S. citizen identification card issued by the Immigration and Naturalization Service ^b	
	Northern Mariana identification card	
	American Indian card	Limited to cards issued by the Department of Homeland Security to Texas Band of Kickapoos
	Final adoption decree showing child's name and U.S. place of birth	
	Evidence of U.S. civil service employment	Limited to individuals employed before June 1, 1976
	U.S. military record showing a U.S. place of birth	

Appendix I: List of Acceptable Documents for Proving Citizenship and Identity, as Defined under Federal Regulations

Level of documentation	Acceptable documents	Restrictions
Tier 3 (third level)	Hospital record indicating a U.S. place of birth	Record must be on hospital letterhead and created at least 5 years before initial application for Medicaid, or, for children under 16, near the time of birth or 5 years before application for Medicaid
	Life, health, or other insurance record indicating U.S. place of birth	Record must be created at least 5 years before initial application for Medicaid
Tier 4 (fourth level)	Federal or state census record showing U.S. citizenship or a U.S. place of birth	Record must also show applicant's age
	Seneca Indian tribal census record	Record must show a U.S. place of birth and have been created at least 5 years before application for Medicaid
	Bureau of Indian Affairs tribal census records of the Navajo Indians	Record must show a U.S. place of birth and have been created at least 5 years before application for Medicaid
	U.S. state vital statistics official notice of birth registration	Notice must show a U.S. place of birth and have been created at least 5 years before application for Medicaid
	U.S. birth record amended more than 5 years after individual's birth	Record must show a U.S. place of birth and have been created at least 5 years before application for Medicaid
	Signed statement from physician or midwife present at birth	Statement must show a U.S. place of birth and have been created at least 5 years before application for Medicaid
	Medical record	Record must show a U.S. place of birth and have been created at least 5 years before initial application for Medicaid or, for children under 16, near the time of birth or 5 years before application for Medicaid
	Institutional admission papers from nursing home or other institution	Papers must show a U.S. place of birth
	Written affidavit	Affidavits may be used only in rare circumstances and must comply with several additional requirements

Source: GAO analysis of the Deficit Reduction Act of 2005 (DRA) and regulations published by CMS.

^aDocument identified in the DRA as an acceptable document for proving citizenship.

^bDocument identified in the DRA as an acceptable document for proving citizenship when accompanied by documentation of identity.

Appendix I: List of Acceptable Documents for Proving Citizenship and Identity, as Defined under Federal Regulations

Table 5: Acceptable Documents for Proving Identity, as Defined under Federal Regulations

Level of documentation	Acceptable identity documents
Tier 1	Not applicable
Tiers 2, 3, and 4	<ul style="list-style-type: none"> • Driver’s license with photograph or other identifying information^a • School identification card with photograph^a • U.S. military card or draft record^a • Identification card issued by federal, state, or local government with photograph or other identifying information^a • Military dependent’s identification card^a • Native American Tribal document^a • U.S. Coast Guard Merchant Mariner card^a • Certificate of Degree of Indian Blood or other tribal document with photograph or other personal identifying information • Cross match with other government agency if the agency establishes and certifies true identity of individuals <p>In addition, for children under 16:</p> <ul style="list-style-type: none"> • School records • Written affidavit if no other identity documents on the list are available

Source: GAO analysis of the DRA and regulations published by CMS.

^aDocument identified in the DRA as an acceptable document for proving identity.

Appendix II: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

JUN 14 2007

Mr. James Cosgrove
Director, Health Care
United States Government Accountability Office
Washington, DC 20548

Dear Mr. Cosgrove:

Thank you for submitting the Draft Report: States Report Citizenship Documentation Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens. We appreciate the opportunity to comment, and have several concerns we would like to address. The Centers for Medicare & Medicaid Services (CMS) is concerned that the title of this report is misleading, given the results of the survey and the lack of supporting data. Although CMS does not disagree generally with the approach of the report, we believe that GAO reached conclusions largely based on State responses that are not substantiated by State enrollment data.

We understand GAO undertook this survey to analyze the impact of the new Deficit Reduction Act of 2005 (DRA) provision requiring States to secure from applicants and recipients for Medicaid satisfactory documentary evidence of citizenship. The provision requires that as of July 1, 2006 citizens applying for Medicaid, or renewing their eligibility, document their citizenship. United States citizenship or legal immigration status has always been a requirement for Medicaid eligibility, but prior to the DRA, States could accept a citizen applicant's statement of citizenship as sufficient. The new law is designed to ensure that Medicaid beneficiaries who are citizens have documented such status without imposing undue burdens on them or the States. This provision does not apply to applicants and recipients who are in a legal immigration status. Such individuals continue to provide documentation of their immigration status as previously required.

The GAO sought to determine whether States were experiencing declines in Medicaid enrollment because of the citizenship documentation requirements. Based on a survey devised by the GAO, the GAO found that of the 44 States that provided complete responses to the GAO survey, 22 reported some declines in Medicaid enrollment, which may be attributable at least in part to the citizenship documentation requirement. Twelve States reported no decline in enrollment and 10 States did not know the effect of the requirement on enrollment. The GAO refused to provide CMS the names of the 7 States that did not complete the survey or fully implement the program. The GAO also did not provide us the individual responses from the State survey. This information would be helpful in identifying problems related to implementation and to showing best practices among the States.

GAO asks the States to establish causality between the implementation of the documentation requirement and enrollment declines, yet States do not identify data sources that validate the relationship between the implementation of the documentation requirement and enrollment

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levels. In addition, we believe the report vastly overstates the conclusions that may be drawn from the information presented within. These conclusions are largely based on anecdotal statements or vague feelings by some States that all declines in enrollment must be based on the new requirements. In fact, enrollment generally ebbs and flows across States such that at any given time one would expect declines in some States, increases in other States, and unchanging enrollment levels in others.

The validity of the report's conclusions is problematic. Broad conclusions on impact appear to be drawn from data provided by one State and generalizing this to other States seems questionable. We also find that the numbers presented are not put into context so that the reader may understand the relative number of impacted applicants and recipients compared to those who do not experience difficulty in meeting the requirement. In addition, we do not believe the report gives sufficient attention to the effort by CMS to minimize the impact of this requirement on States.

We agree that some States did report challenges. However, this result was not universal. Half of the States responding did not report declines specific to this requirement. And, even though 22 States reported declines in Medicaid enrollment, the majority of those States reported that this decline was primarily caused by applicants experiencing some *delay* in receiving coverage, rather than a denial in coverage. Moreover, even when reporting this delay, States did not have the factual information to substantiate that the citizenship requirement was in fact the basis for the delay in enrollment.

We appreciate the effort GAO undertook in doing this report and understand the difficulty of drawing clear conclusions due to the fact that States have relatively little specific data on the reasons for the decline in enrollment. While it is still useful to have the benefit of the information States provided about their implementation experiences, the limitations of such information should be recognized. Furthermore, the survey instrument itself has several weaknesses. Question 7 uses the term "appeared eligible." This is a vague and subjective concept which tends to lead the respondent to certain conclusions rather than being precise, because there are many reasons that someone who may "appear" at first meeting to be eligible is ultimately found ineligible. Questions 16 and 17 ask what application method was/is most commonly used, such as mail-in, in person, etc. It is the experience of CMS that States use multiple methods of taking applications that in many cases are unique to specific eligibility groups. Without this information, it is difficult to make worthwhile conclusions. Question 34, did not ask for the number or percentage of applicants experiencing the barriers listed.

The report describes State implementation experiences after less than one year implementing a new documentation requirement. States for 10-15 years prior to implementation had been generally relying on self declaration without verification except in unusual circumstances. The generalized practice of minimizing documentation over these years followed by an abrupt shift to more documentation unsurprisingly has caused some challenges for States in operationalizing the new requirements in a very short timeframe. With little time to prepare for a major shift in outlook by States, eligibility workers, and the client population, the rather small declines generally being reported are a testament to the success of States' implementation. The report also sheds very little light, beyond the presupposition that citizens are the ones unable to

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document their citizenship, about whether the provision is deterring nonqualified aliens from applying for regular Medicaid.

Among the major complaints of States, as reported by the GAO, is the requirement that originals of documents be submitted, especially when the application process is a mail-in process. Consequently, the requirement for originals of documents presents some administrative challenges. In this context, we note that the Social Security Administration (SSA) requires originals prior to establishing eligibility. Likewise, the Department of State requires original documents or certified copies prior to issuing a passport. We also considered the option of permitting copies, but concluded that program integrity would best be served by requiring originals or certified copies.

The GAO indicates in the report that CMS may have overestimated potential savings in the interim final rule with comment period. CMS notes that the regulatory impact statement was calculated to estimate changes in Medicaid expenditures for claims. It did not account for the administrative impact on States. With respect to administrative costs, CMS provides federal match for administrative expenditures. We would expect States to experience higher administrative costs during the first year of implementation as they adjust to the new requirements. We also expect these costs to decrease in later years as current recipients meet the requirements and only new applicants are required to submit documentation. Furthermore, the exemption of several groups of individuals authorized under both the DRA and the Tax Relief and Health Care Act of 2006 (TRHCA) will significantly reduce the number of individuals from whom States must collect documentation. Administrative costs may be further reduced by the States' ability to cross-verify with the Systematic Alien Verification for Entitlements (SAVE) database, to which they already have access. Data matches with the State's vital statistics agency could further reduce administrative costs.

The CMS has undertaken a number of positive steps to implement the citizenship documentation requirements. Among these are: (a) issuing a State Medicaid Directors' letter and interim final rule soon after publication of the DRA which expanded upon the documents that could be used in proving identity and citizenship; (b) providing extensive leadership and training to the States so that they could implement the requirement; (c) working closely with the SSA and other agencies to ensure that the requirements reflected standards already used by other Federal agencies that verify citizenship; (d) working on the issuance of a final rule that should be issued shortly and that will respond to comments; and (e) encouraging States to use electronic matching whenever possible. We believe that these activities play a vital role in assisting the States in understanding the new documentation requirements under the law. Conveying all of this information to States and beneficiaries is a massive undertaking and we anticipate that with time the documentation requirements will be recognized and understood as another aspect of the Medicaid eligibility process.

CMS has attempted to provide as much flexibility as possible and consistent with the provisions of the DRA in the documents applicants and recipients could use to document citizenship. Further, any requirement to provide documentation by its nature adds to the responsibility of the individual and the workload of the State. We also believe any initial impact has diminished as States and applicants become familiar with the documentation requirement. We expect to see a

**Appendix II: Comments from the Centers for
Medicare & Medicaid Services**

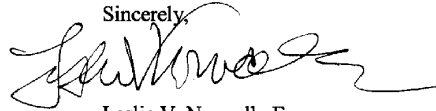
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reduction in delays or denials for lack of documentation once the startup issues are resolved. Moreover, we are pleased with the more expansive list of documents that has been published to assist States in fulfilling the statutory documentation requirement. We believe that through these documents and/or data matches, States have sufficient tools to assure that any citizen can provide the necessary documents to meet the documentation requirement, and the State will not be found at risk for providing Medicaid to undocumented citizens.

Our goal from the beginning has been to minimize the incidence of delays in or denials of eligibility because of this provision. Thus, we have encouraged States to conduct data matches with vital statistics agencies and other governmental agencies for identity. The information we have received from States indicate that producing identity documents for young children has been the largest problem States have encountered, and we will clarify this issue in the final regulation.

We conclude also by noting that GAO made no recommendations to CMS in the report. Enclosed are additional technical comments. Again, thank you for the opportunity to comment. If you have any questions please feel free to contact me.

Sincerely,



Leslie V. Norwalk, Esq.
Acting Administrator

Enclosure

Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

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