

**Unintended Consequences:**  
*The Impact of the New Medicaid Citizenship  
Documentation Requirements  
On Virginia's Children*



*May 2007*

The Virginia Health Care Foundation (*VHCF*) is a public/private partnership devoted to increasing access to primary health care for uninsured and medically underserved Virginians, by strengthening and growing Virginia's health care safety net. The Foundation was created in June 1992 by the Virginia General Assembly and its Joint Commission on Health Care.

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**Unintended Consequences:  
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on Virginia's Children**

**Executive Summary**

Among the requirements of the Deficit Reduction Act (*DRA*) of 2005 is a provision requiring documentation of citizenship and identity for all those applying for or renewing eligibility for Medicaid. This was added to prevent illegal immigrants from obtaining public benefits intended for U.S. citizens. Instead, the new federal requirement has hampered Virginia's ability to enroll eligible, uninsured children.

A study conducted by the Virginia Health Care Foundation (*VHCF*), in partnership with the Virginia Department of Medical Assistance Services (*DMAS*), has found that the new requirements have had a much broader impact than expected, adversely affecting thousands of *citizen* children since implementation last July. The unintended consequences include:

- A significant decrease in the number of children enrolled in Medicaid in Virginia;
- 4-6 month delays in obtaining Medicaid coverage for Virginia children;
- Inability of citizen children to obtain medical care; and
- A dramatic increase in emergency room utilization by those caught up in lengthy eligibility determinations.

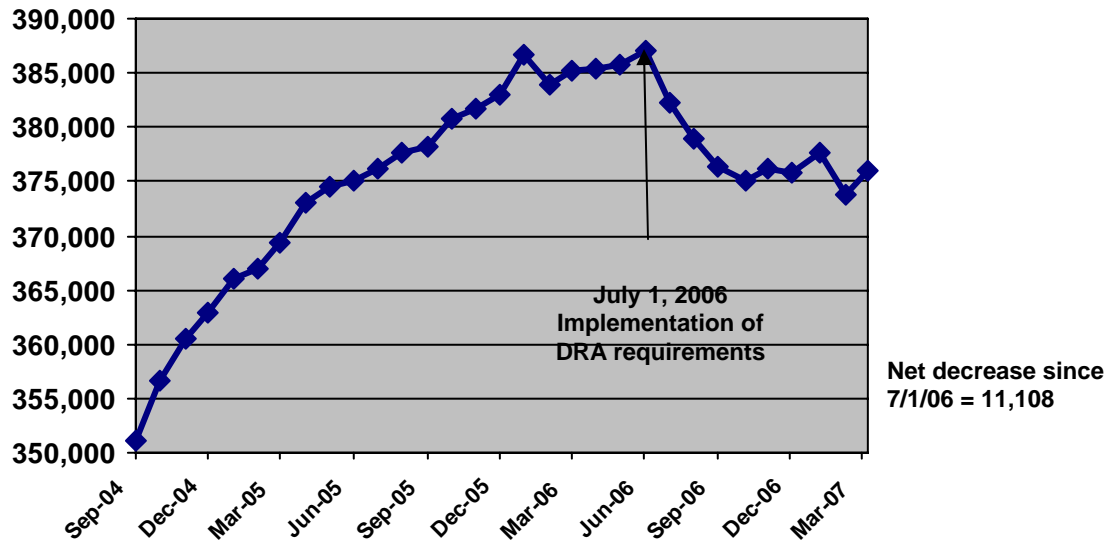
These requirements have also increased costs and administrative burdens to state and local government agencies, which have required additional tax dollars.

**Medicaid Enrollment Has Declined Dramatically, While SCHIP Enrollment Continues to Grow**

After years of steady growth and an average net increase of 1000 children per month in the 12 months immediately preceding the implementation of the new requirements, there has been a dramatic decline in the number of children enrolled in Virginia's Medicaid program since the requirements took effect.

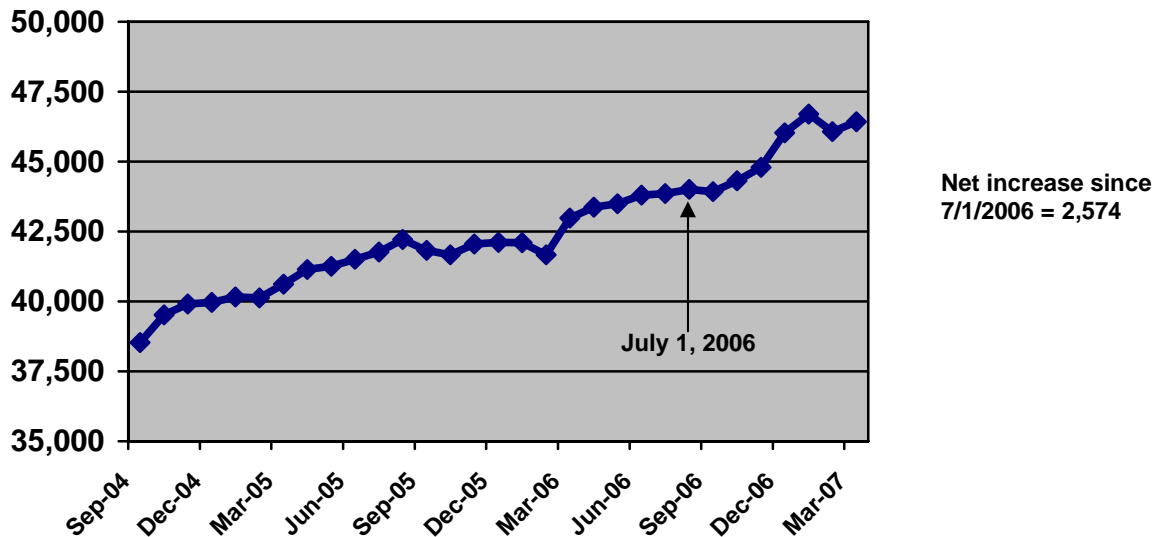
- Specifically, there was a **net decrease of 11,108 children enrolled in Virginia's Medicaid program** in the first nine months of implementation (7/06 – 3/07).

### Monthly Net Enrollment of Children in Medicaid (2004-2007)



In contrast, the monthly net enrollment of children in Virginia’s SCHIP Program (*FAMIS*) continued to increase during the same period of time. SCHIP does not have the same type of requirements for proving citizenship and identity.

### Monthly Net Enrollment of Children in SCHIP (2004-2007)



Given the similarities in the two programs, and the continuous growth in SCHIP, it is reasonable to conclude that enrollment in Virginia’s Medicaid program would have continued increasing as well, in the absence of the new requirements. In fact, at the pre-regulation rate of monthly net increase (1000), an additional 9000 children would have been enrolled in Medicaid during the first nine months of implementation.

When the impact of decreased Medicaid enrollment (11,108) and the elimination of monthly growth (9000) are combined, **over 20,000 Virginia citizen children have been adversely affected**, and unintentionally impacted during the **first nine months** of the new requirements.

## Survey Shows Delayed Coverage and Unavailability of Needed Care for Citizen Children

In an effort to “look behind” the enrollment data and to understand the overall consequences of the documentation requirements, VHCF contracted with *Matrix Research Group* to conduct a telephone survey of 800 adults<sup>1</sup>, who applied for Medicaid for their citizen children<sup>2</sup> through DMAS’ Central Processing Unit (CPU) after the requirements were implemented. The survey results document a variety of troubling and unintended consequences.

### ***Coverage is Delayed***

The survey found that more than half of the children who were not yet enrolled at the time they were surveyed had been **waiting for four months or more** for their applications to be processed.

- For those who were enrolled at the time of the survey, **72% required more than the allowable 45 days to process, with 21% taking more than 76 days.**

These delays, which seriously affected children’s access to care, are atypical for the CPU, which needed an average of *only 16 days* to process a child’s Medicaid application in the six months *prior to implementation* of the new requirements.

### ***Access to Care is Compromised; Emergency Room Use Escalates***

While waiting for their children’s enrollment to be approved, **90% of those surveyed said they had no other health coverage for their child.** Of those:

- **65% reported needing some type of health care during that time.**
- **41% of those children who needed care were not able to get all of the care they needed.**
  - **Almost half (47%), of the young children (aged 0-24 months) who needed immunizations were unable to get them.**
  - **41% were unable to access dental care, 24% did not obtain medical care for an illness, and 17% couldn’t fill needed prescriptions.**
- The most frequently cited reason that parents said they were unable to obtain health care for their children is that **they couldn’t afford it (72%).**
- In addition, there was a **significant increase in the use of hospital**

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<sup>1</sup> The survey sample was drawn from approximately 3000 adults who applied for Medicaid for their children after July 1, 2006. It included 509 adults whose children were enrolled at the time of the survey, and 291 adults who had applied during the same period, but whose children were not yet enrolled. Except where noted, there were no significant differences in the responses of the sample groups.

<sup>2</sup> The survey targeted those who reported that their children were U.S. citizens. Matrix used several methods to confirm citizenship, including a question asking for the name of the U.S. hospital in which a child was born. 93% of respondents were able to respond to this question without difficulty. Given the challenges of obtaining original documents (31% were born in a state other than Virginia), and the delays in processing applications, a portion of the survey group was not enrolled in Medicaid at the time of the survey. At this point, 80% have been approved, and the remaining cases are pending while parents and caseworkers work through the costly, time-consuming process of obtaining original documentation.

**Emergency Rooms (ER) for primary care**, by parents who indicated that they do not normally use the ER as their usual source of care. Only 3% of surveyed parents reported that ERs are the usual source of care for their children. But 18% indicated that their children had to use an ER for treatment while the processing of their application was delayed.

## **Implementing the Requirements is Costly and Undermines Recent System Efficiencies**

The requirement to prove citizenship and identity has taken a toll on the state and local agencies responsible for administering the programs, as well.

### ***Impact on State Agencies***

At the state level, the CPU's "**pending**" cases, (*those awaiting further documentation*), skyrocketed **from about 50 a month** before the new requirements were implemented **to 4000 in January**.

- To address the backlog, the CPU had to hire seven additional staff and provide accompanying space, phones, and computers. **Extra costs in the first year alone will total more than \$144,000.**
- This does not include the costs of obtaining out-of-state birth certificates, (*\$25-\$50 each*). In just the first six weeks of implementation, local departments of social services received 900 requests for assistance in obtaining out-of-state birth certificates.

### ***Impact on Local Agencies***

To learn more about the impact at the local level, VHCF conducted focus groups with eligibility workers at five local departments of social services in different regions of the state. All reported a **significant increase in workloads** as a result of the requirements for original documentation of citizenship and identity.

- Eligibility workers reported that they are taking **more phone calls**, and that the **calls last longer**. They indicate **parents call repeatedly** to check on the status of their applications, and to **ask for help** in finding **care for their sick children** during the delays in enrollment.

These difficulties are reflected in the dramatic change in Medicaid applicants' experience with the application process. The survey found that **40% of respondents reported the Medicaid application process to be difficult, compared to only 8%** in a similar survey conducted **in 2004**.

- Getting paperwork together (36%), obtaining answers to questions (24%), and understanding what was needed (22%), were the most frequently identified difficulties.

## Conclusion

Unfortunately, the requirement for original documentation of citizenship and identity has resulted in unintended, adverse consequences. While waiting for their health coverage to be approved, Virginia children have gone without needed medical care, including care for illness or injury, immunizations, dental care and prescription medications. All evidence indicates that these are US citizen children, born in U.S. hospitals, with *more than two-thirds born in Virginia*.

The new requirements have also had a serious impact on state and local agencies responsible for administering the Medicaid program, and have undermined Virginia's previously successful efforts to simplify and streamline application procedures.

Virginia's impressive progress in enrolling eligible children in the Medicaid program is being diminished by these requirements, and the health of thousands of Virginia's most vulnerable children is threatened.

## BACKGROUND

In February, 2006, President Bush signed the Deficit Reduction Act (*DRA*) of 2005. Among its provisions were a number of mandatory changes to state Medicaid Programs. One of the changes, effective July 1, 2006, **requires documentation of both citizenship and identity when applying for or renewing Medicaid eligibility**. In interim regulations governing this provision of the DRA, the Centers for Medicare and Medicaid Services (*CMS*) specified a hierarchy of acceptable forms of proof and required that such **documents must be originals**. While some groups have been exempted, most children and pregnant women must meet this new requirement.

U.S. citizenship or legal immigration status has always been a requirement for Medicaid eligibility. Until now, however, beneficiaries could simply assert their citizenship status, under penalty of perjury, by checking a box on a form. The DRA has changed this approach and requires **actual documentary evidence** (*a U.S. passport or a combination of a birth certificate and another form of identification*) before Medicaid eligibility is granted or renewed.

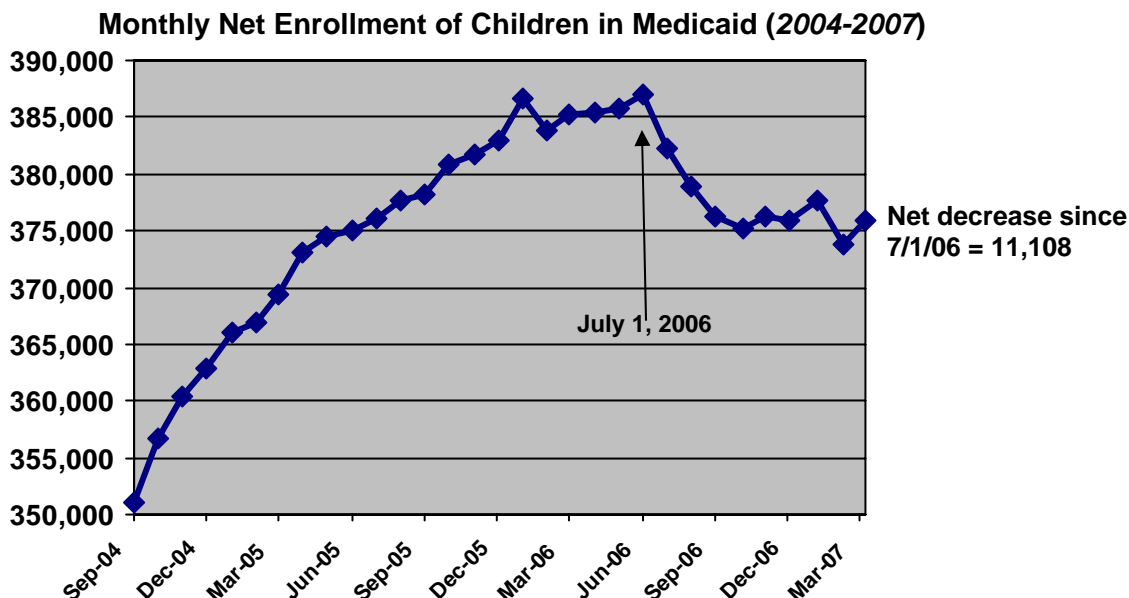
In order to determine the impact of the new requirements for citizenship and identity documentation, the Virginia Health Care Foundation (*VHCF*), in partnership with the Virginia Department of Medical Assistance Services (*DMAS*), undertook this study. *DMAS* conducted regular analyses of enrollment trends and of the impact of the rule change on state systems. *VHCF* surveyed parents who applied for Medicaid on behalf of their children after the DRA requirements were implemented, and conducted focus groups with Medicaid eligibility workers at the Medicaid Unit of the CPU and in a local department of social services in 5 different regions of the state. The survey of parents was conducted in February and March 2007 and the focus groups occurred from January through April 2007. All of these analyses are included as part of this report.

This new requirement was intended by its sponsors to keep illegal immigrants from fraudulently enrolling in Medicaid. Yet, this study found that, for a significant number of eligible U.S. citizen children, coverage has been impeded or delayed. There is strong evidence that these requirements have had a significant, negative impact on Medicaid enrollment, on children's health care, and on state and local administrative systems in Virginia.

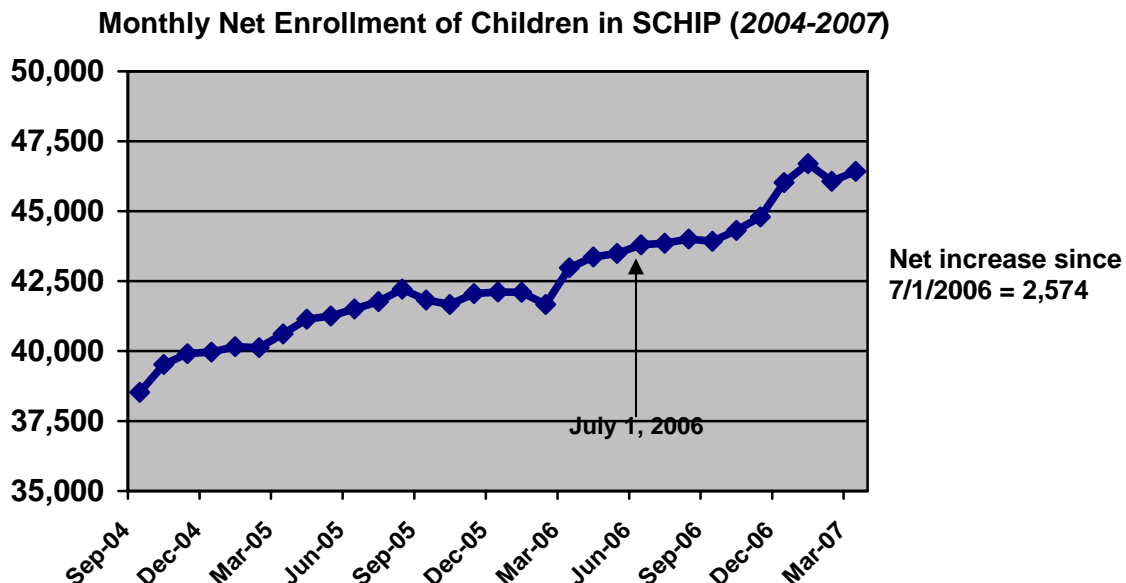
## INITIAL IMPACT of CITIZENSHIP and IDENTITY REQUIREMENTS

### Impact on Enrollment of Children in Medicaid in Virginia

On July 1, 2006, there were 430,878 children enrolled in Virginia's FAMIS (*SCHIP*) and FAMIS Plus (*Medicaid*) Programs<sup>1</sup>. In the categories affected by the DRA requirements (*FAMIS Plus and SCHIP Medicaid Expansion*), there has been a **net decrease of 11,108** children in the nine months since the provisions of the DRA were implemented. In the 12 months prior to the implementation of the requirements for citizenship and identity, Virginia saw an average net increase of 1,000 children per month in Medicaid, indicating that as many as **20,000 Virginia children have gone without coverage as a result of these requirements**.



This compares with enrollment increases in FAMIS (*Virginia's SCHIP Program, not currently affected by the new requirements*) during the same period of time.



<sup>1</sup> Virginia's Medicaid Program for children is called FAMIS Plus. Unless otherwise noted and explained, this document uses the term Medicaid in order to be clear for readers from outside Virginia.

## Virginia's Immediate Response

In September, 2006, Governor Timothy Kaine authorized DMAS and DSS to take several actions to try to “stop the hemorrhaging.” These included:

- Extending the timeframe for processing applications to give Medicaid applicants “reasonable opportunity” to provide documentation (*30 calendar-day extension and an additional 10 working days if information has been requested but not received*);
- Coordinating with the Virginia Department of Health Bureau of Vital Records (BVR) to certify copies of Virginia birth certificates for local DSS offices at no cost to applicants;
- Deputizing selected outreach organizations to certify that they viewed applicants' original documents.
- Revising policy to allow local DSS offices and CPU to accept *copies* of Virginia birth records and immediately enroll eligible individuals pending certification of the birth record by BVR;
- Revising the child health insurance application form to include an affidavit of identity (*Federal law specifies that parents may attest to the identity of children younger than 16*); and
- Agreeing to pay the required fees for obtaining out-of-state birth certificates, and implementing a process for DSS to receive requests from local offices and submit them to appropriate offices in other states (*implemented February 2007*).

Because Virginia's 121 departments of social services are locally-administered, it took several months for these changes to be fully implemented and for any impact to be realized. Statewide DSS data systems are not adequate to monitor the number of children whose applications are denied or pending due to lack of documentation, for example, and some local departments report difficulty keeping up with the frequent changes to Medicaid eligibility policies and procedures. In addition, since implementation of the process for securing out-of-state birth certificates, the Department of Social Services has received 1400 requests for assistance. DSS reports that several states have refused to respond to Virginia's request on behalf of applicant children, requiring parents to request their children's out-of-state birth certificates individually.

## Impact on State Systems

Processing of Medicaid applications for children and pregnant women is handled by Virginia's 121 local departments of social services and by Virginia's Central Processing Unit (CPU). The CPU, administered under contract with the Department of Medical Assistance Services (DMAS), has reported significant impact since implementation of the requirements for documentation of citizenship and identity.

The number of calls received by the call center increased dramatically, and many more calls have been lost (“*abandoned*”) because workers could not get to them before callers hung up. The number of applications processed to decision each month by the Medicaid Unit located at the CPU has dropped significantly in the months following implementation. The number of “pending” Medicaid cases (*those awaiting further documentation*) is now approximately 2,500 (*having reached 4,000 at its highest point in*

January 2007), compared to approximately 50 applications pending at any one time pre-DRA.

<b>Central Processing Unit (CPU)</b>	<b>Monthly Average Prior to July 2006</b>	<b>Monthly Average July thru December 2006</b>	<b>Monthly Average January thru May 2007</b>
Calls Received	12,500	19,600 (Peak of 23,000)	17,674
Abandoned Call Rate	3.7%	23%	7.4%
Applications Received	3,855	4,084	4,183
<b>CPU Medicaid Unit (Processes Medicaid applications submitted to CPU)</b>	<b>Monthly Average Prior to July 2006</b>	<b>Monthly Average July thru December 2006</b>	<b>Monthly Average January thru May 2007</b>
# Staff	5 Full-time Eligibility Workers 3 Part-time Admin Support Workers	5 Full-time and 2 Part-time Eligibility Workers 4 Part-time Admin Support Workers	5 Full-time and 3 Part-time Eligibility Workers 6 Part-time Admin Support Workers
Calls Received	93	600	2,500
Abandoned Call Rate	N/A		12.5%
Applications Processed	1,384	751	1,350

## FOCUS GROUPS OF MEDICAID ELIGIBILITY WORKERS

Eligibility workers in local departments of social services and at the Central Processing Unit (CPU) are the first individuals with whom most parents interact when they apply for Medicaid for their children. Eligibility workers are on the “front lines,” answering parents’ questions, explaining program policies, and reviewing application forms. At the local DSS, most eligibility workers have responsibility for processing applications for several different benefits programs, including food stamps and Temporary Assistance to Needy Families (TANF), as well as Medicaid.

In light of their important role in the Medicaid application process, VHCF was interested in gaining the perspective of these workers about the impact of the citizenship and identity requirements on their work, on their local offices, and on the families they serve.

### Methodology

Medicaid eligibility workers in local social services departments representing all five regions of the state were invited by VHCF to participate in focus groups. In addition, an invitation was extended to the Medicaid Unit at the CPU. Focus groups were held from January through April 2007. The five local departments (*Chesterfield, Loudoun, Russell, and Tazewell Counties and the City of Virginia Beach*) were selected to reflect the experiences of urban, rural, and suburban localities.

Group discussions were held on-site at the local offices and the CPU. Groups ranged in size from 4-15 workers and were facilitated by VHCF staff. A standard set of questions was asked of each group and responses were recorded in writing. No names were recorded and responses are presented in the aggregate.

In general, the eligibility workers were happy to have the opportunity to share their opinions and experiences. As a group, they expressed concern about the impact of the new requirements on children and frustration in not being able to help children get enrolled as quickly as they had before.

### Findings

#### ***Families Have Had Difficulty Meeting Documentation Requirements***

- By far, the most difficult piece of documentation for families to produce has been the **original birth certificate**.
  - Parents report they never received a birth certificate from the Bureau of Vital Records (BVR). (*In Virginia, birth certificates are not automatically provided to parents. Parents must request a birth certificate and pay a fee.*) Many reported having “proof of birth” letter from hospital where child was born, and assuming that was sufficient documentation.
  - **Fees** for out-of-state birth certificates range as high as \$50 and parents are usually unaware of the procedures for obtaining them.
- **Identity documentation for children older than 16** is also very difficult to obtain. (*In some localities, the Department of Motor Vehicles will provide a picture identification card for \$10, provided the applicant has an original birth certificate.*)

- The CPU reported that fewer than 5% of cases referred to the Medicaid unit have all of the required documentation for citizenship and identity.
- There has been a demonstrable impact on renewal applications as well. One small local department reported that 50-60 anticipated renewals each month were not received.<sup>2</sup>

### ***Parents are Confused and Troubled***

- According to the eligibility workers, many parents do not seem to understand the terms “citizenship” and “identity” in the context of these requirements. Eligibility workers spend a great deal of time explaining the terms and the required documentation.
- Many parents seem to believe the Social Security number should be adequate documentation, since it is accepted as documentation of identity for Food Stamp applications.
- Eligibility workers reported parents repeatedly asking the same questions:
  - Where do I get my child’s birth certificate?
  - How long will it take for my child to get enrolled?
  - What should I do if my child gets sick [while waiting to be enrolled]?

*Workers report a negative impact on their relationship with families. Families ask why “we are being so difficult... we’ve always accepted them at their word before.”*

### ***Families Report Impact on Children***

Parents have reported to eligibility workers that they have delayed health care for their children because of inability to pay for it.

- Families report feeling overwhelmed and often appear to be “in crisis.”
- Parents reported that community physicians would not see their children without coverage, even if their child’s Medicaid application was pending.
- Parents don’t always tell workers what the issues are and don’t ask for help. “They just give up.”

*“We had a very sick baby in [a local hospital]. She needed to be transferred to get special care. The hospital would not transfer her unless I could guarantee she’d have Medicaid. I could not do that without her documents. How am I supposed to sleep at night?”*

### ***Workload has Increased Dramatically***

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<sup>2</sup> In November, 2006, the Virginia Department of Social Services (VDSS) added a new cancellation code to its statewide data system to identify those children whose coverage in Medicaid was cancelled for failure to provide documentation of citizenship, identity, or both. From January through May of 2007, 1383 **children lost their Medicaid coverage** at the time of redetermination because they did not provide the necessary documents. Local eligibility workers who participated in the focus groups believe this number under-reports the true extent of the problem. In their experience, when parents realize that they do not have the documents they need to prove their child’s citizenship or identity, they “don’t bother” with other required documentations (*i.e., income statements*) so their coverage is cancelled for other reasons.

- Eligibility workers report **increased volume** has been the most significant change to the workload since implementation of the requirements for documentation of citizenship and identity.
  - Workers are taking more phone calls and calls last longer. Call abandonment rate at the CPU has increased.
  - More written correspondence is sent to families.
  - Documenting phone calls and written correspondence takes more time.
- Regularly reviewing files to determine whether documents have been received **slows the process.**
- **The new rules have made the streamlined application procedure more difficult to implement.** (*Virginia had simplified the application and renewal process by eliminating the requirement for face-to-face meeting*).
- Workers are serving fewer children because everything takes longer.
- More **“traffic” at the LDSS front desk** as parents bring in required documents.
- Workers report feeling **“swamped with paper”** and frustrated by the process.
- Many local offices report difficulty keeping up with all of the changes. They have been notified through frequent broadcast e-mails from the DSS Central Office, meetings with DSS Regional Specialists, and Supervisor Meetings, but information often takes weeks to work its way through the local offices. Eligibility units report **“constant meetings”** to address changes to policy and procedures, and some workers remain confused about which new policies to apply at any given time.
- Workers report they often have all of the documentation they need for one or two family members, but not for another. While they can enroll the eligible members for whom they have the documentation, they can’t enroll the others and the case stays “pending.”
- **Processing time, even for complete applications, has increased.** Before July 1, average processing time for a complete application at one large local DSS was 4-5 days. Since July 1, “all of us are at deadline (*45 days to process*), even if [parents] have everything they need.”
- Workers report giving parents as much time as possible to provide the documentation, extending the deadline for an additional 40 days “if parents report that they are working on it.” (*New policy allows for one 30 calendar-day extension, with an additional 10 business days, if necessary.*) Eligibility workers, however, cannot authorize this additional time unless parents specifically request it.

*“We are just spending so much more time handling each case... we touch the case many more times than before.”*

## Policy and Procedural Changes Have Helped

Virginia began to see a decrease in net enrollment of children in Medicaid immediately after the new requirements were implemented. In order to mitigate the impact of these requirements, Governor Kaine authorized a number of changes to policy and procedures.

- Eligibility workers were authorized to **accept copies** of birth certificates for Virginia-born children and, if a child is found to be eligible, **enroll the child while awaiting certification** from Vital Records.
  - CPU workers reported this change to be helpful, because the child gets enrolled and may begin receiving services, but the application is still “pending” and **continues to need their attention** until the documents have been provided.
- The other change that workers report had the most positive impact was adding the *Affidavit of Identity* for children under age 16 to the Health Insurance Application for Children and Pregnant Women.

*“We will always go the extra mile for a child if we can. I want to keep kids on coverage, not kick them off!”*

## Workers Offered Suggestions for Change

Eligibility workers were asked to suggest ways in which other procedures and/or systems might be changed to improve their ability to manage these requirements and minimize the barriers to enrollment of eligible children. Their suggestions included:

- Eliminating the requirement for original documentation of citizenship and identity.
- Enhancing “Spider” (*VDSS electronic data match system*) to allow access to data held by the Bureau of Vital Records.
- Requiring hospitals to facilitate the application for birth certificate before infant leaves the hospital
- Implementing a public awareness campaign: “How to get your child’s birth certificate!”
- Using technology to help workers “work smarter.”
- Recognizing the skill and experience of eligibility workers. They verify information for other benefit programs and “know how to do it!”

## SURVEY OF MEDICAID APPLICANT FAMILIES

To determine the impact of the new requirements on Medicaid applicants, VHCF commissioned Matrix Marketing Research Group, Inc. to conduct a telephone survey among adults who applied for Medicaid for their children through the DMAS Central Processing Unit (CPU) after July 1, 2006. The study group included parents with children who had pending applications for enrollment, as well as parents whose children were enrolled at the time of the survey. Questions were related to the application process and on children's access to health care while they were waiting for their coverage to begin.

### KEY FINDINGS

#### Processing of Applications for Citizen Children Was Significantly Delayed

- Among the study population who ultimately enrolled in Medicaid, it took an **average of 64 days to process** a Medicaid application. Prior to July 1, 2006, average processing time for a Medicaid application submitted to the Central Processing Unit was 16 days.
- **Almost three out of four applications (74%) required more than 45 days to process. More than one in four (28%) required more than 90 days.**
- Since July 1, 2006, approximately one-in-five respondents had **applied *more than once for Medicaid*** (19%), or an average of 1.3 times.
- **Virtually all of the respondents (97%) report their children were born in the United States. Of those, 69% were born in Virginia.**
- **Almost all respondents (93%) could name the U.S. hospital in which their child was born.**

#### Parents Were Not Able to Obtain Needed Medical Care for Their Children

- While waiting for their child's Medicaid enrollment to be approved, **90% of those surveyed said they had *no other health coverage* for their child.**
- While waiting for their coverage to begin, **65% of children who did not have other adequate coverage available to them were reported to *need health care* during that time.**
- **Almost 40% of children who needed health care while waiting for coverage were *not able to get all of the care* they needed.**
- The most frequent types of health care that adults were unable to obtain for their children while waiting for coverage were **dental care (41%), regular check-ups (29%), care for an illness (24%), and immunizations (12%).**
- Further analysis by age group found that **nearly half (47%) of young children (birth through age 2) were unable to get immunizations.**
- Of the children who needed a prescription while waiting for coverage, **17% were not able to get the medicine needed.** The leading reason given for why survey

respondents were unable to get their child's prescription was that they could not afford it (91%).

#### Without Coverage, Health Care was Unaffordable and ER Usage Increased

- The primary reason that those adults said they were unable to obtain health care for their children is that **they couldn't afford it (72%)**. Thirty two percent (32%) reported that they were waiting for coverage to begin, also indicating that **affordability was a barrier to care**.
- Only three percent (3%) of parents reported that emergency rooms were their usual source of care, **but six times as many, 18%, went to the ER while waiting for their Medicaid coverage**.

## **DETAILED FINDINGS**

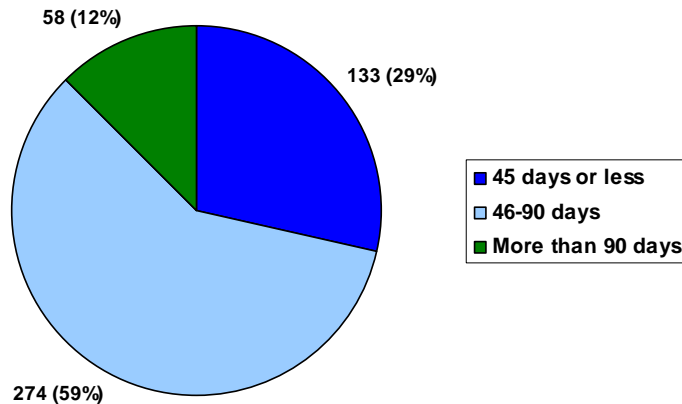
### **Processing of Applications Was Delayed**

Federal law requires that Medicaid applications be processed in 45 days or less. Prior to July 1, 2006, Medicaid applications filed with the CPU required an average of 16 days to process. Virtually all applications were processed in 45 days or less. The survey found that processing of Medicaid applications after implementation of the citizenship and identity requirements took much longer than 45 days for the vast majority of children.

Among the full survey population, three out of four (74%) applications required more than 45 days to process. Of those, more than one in four (28%) required more than 90 days.

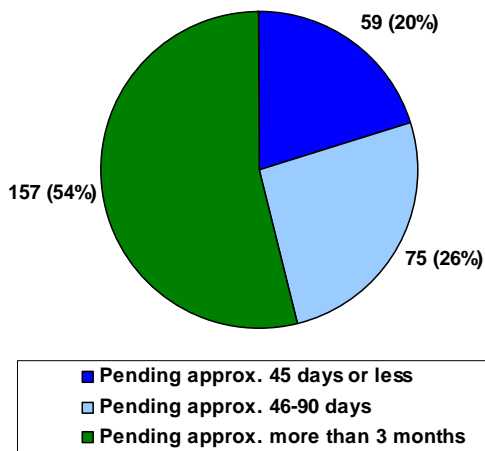
#### *Enrolled Children*

For the children reported to be enrolled at the time of the survey, it took an average of 64 days for these applications to be processed, with a range of 14 – 278 days. Seventy-one percent of these children waited more than 45 days for their applications to be processed; 12% waited longer than 90 days.



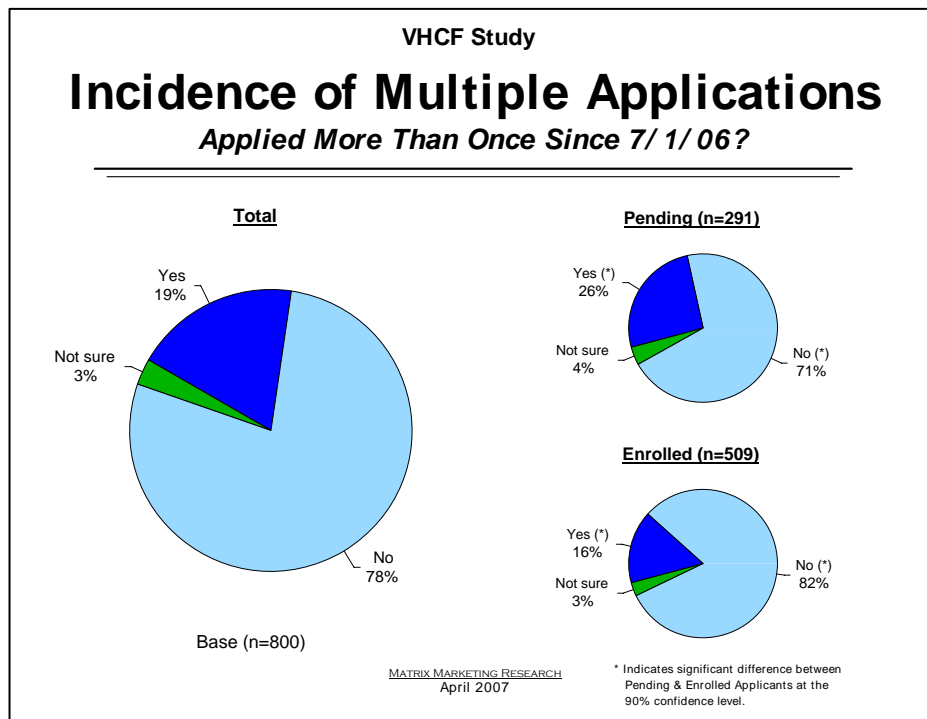
#### *Children with Applications Still Pending*

For the 291 children not enrolled at the time of survey, application dates were analyzed to determine how long the applications had been pending at the time of the interview. More than half of these children were still waiting for coverage more than 3 months after application.



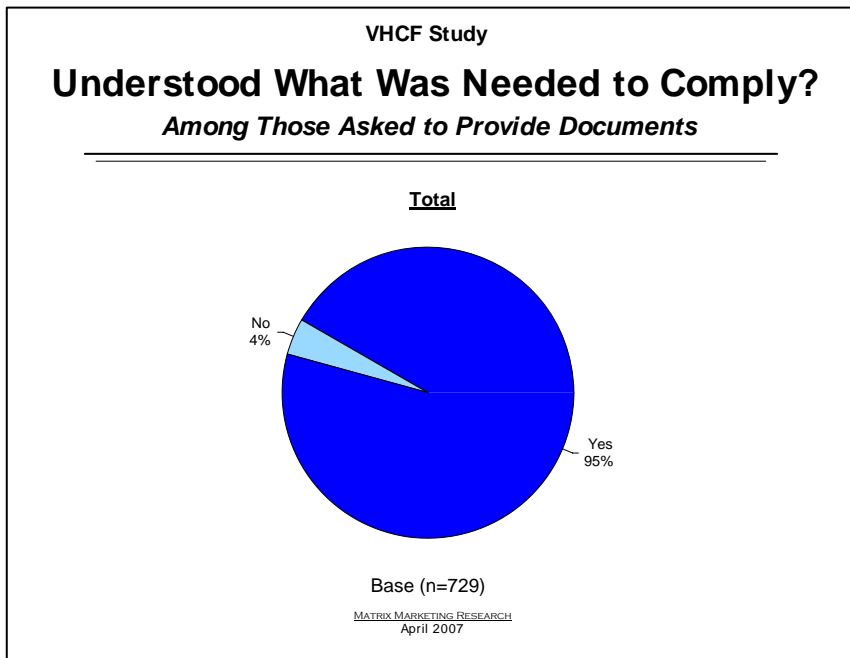
### Incidence of Multiple Applications

Approximately one-in-five adults surveyed reported that they had applied *more than once* for Medicaid since July 1, 2006 (19%). Significantly more respondents with pending applications had applied more than once (25%) than those whose children were enrolled (16%). Applications were made an average of 1.3 times.



**Providing Documents: *Understood Request?***

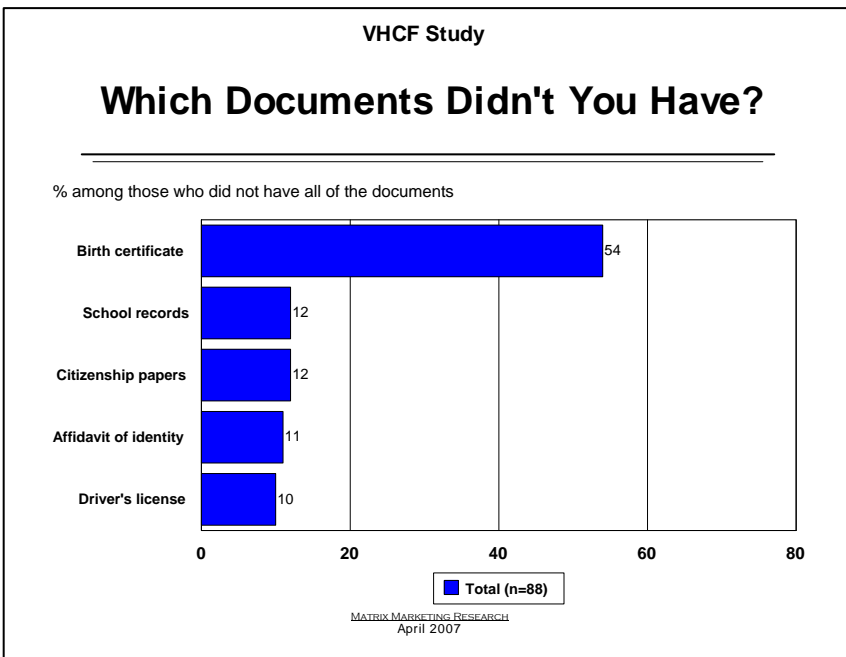
Among adults who recalled being asked to provide documentation of citizenship and identity for their children, virtually all said that they did understand what they needed to send.



Among the very small number of adults who *did not* understand the request (*i.e.*, 34 total survey respondents), most said they didn't understand *what documents* were needed, while others said they didn't understand *why* they needed to provide the documents or said that they did not understand what "identity" meant.

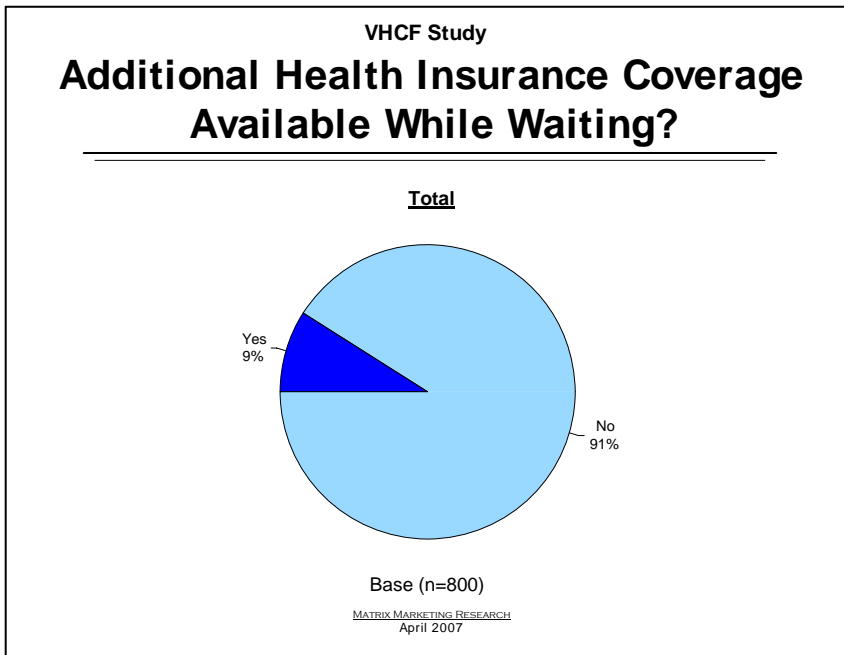
**Providing Documents: *Which Documents Didn't You Have?***

The specific documents these respondents were most frequently unable to provide were *birth certificates* (54%). Mentioned far less often were *school records* (12%), *other citizenship papers* (12%) and *affidavits of identity* (11%).

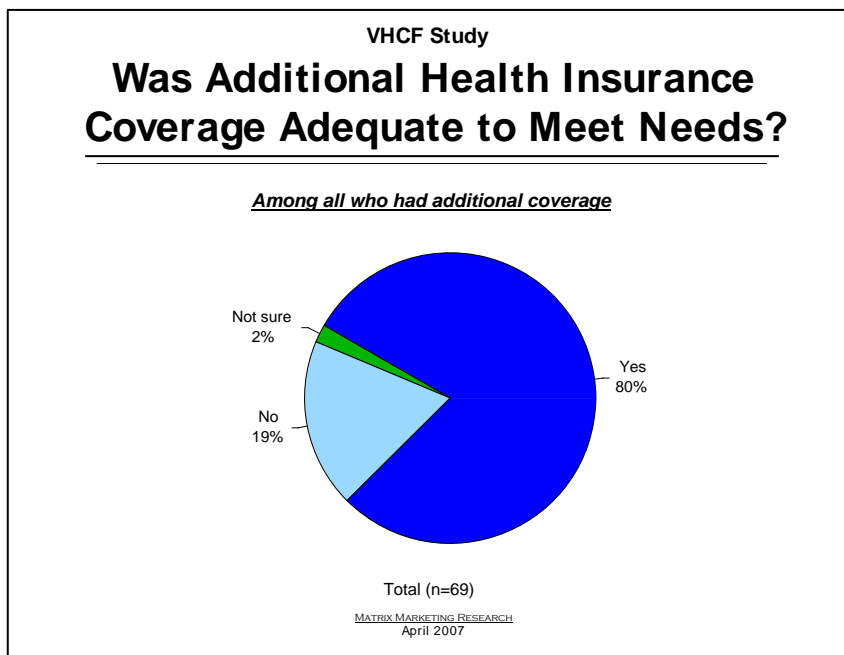


### Additional Health Coverage Available While Waiting?

During the time they were waiting for their child's Medicaid application to be approved, very few adults said they had some other type of health insurance coverage available to cover their child (9%).

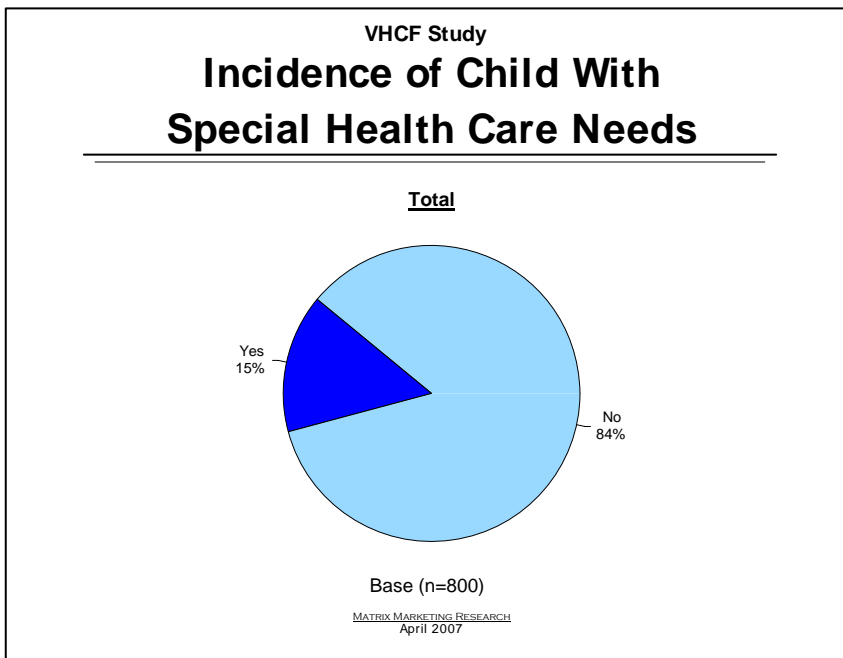


Among the few respondents who did have other insurance available for their child during the waiting time (9%), nearly one-in-five said that the coverage was *not adequate* (19%).



**Child with Special Health Care Needs: Incidence Among Households**

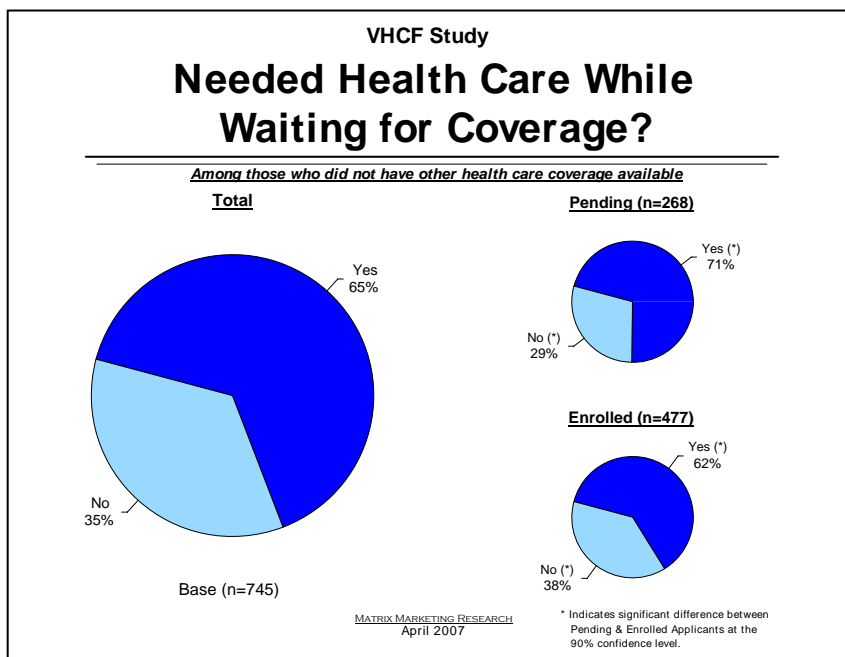
Approximately one-in-seven adults surveyed report that the child asked about in the survey has a special health care need, such as a disability or a chronic illness or condition (15%). This is a group of children for whom uninterrupted, comprehensive care is particularly important.



*(Note: The structure of the study required that adults would be asked only about a specific child by name. It is therefore possible that in some households where the child in question did not have a special need, there is another child in the household who does. Therefore, this finding cannot be used as an estimate of the overall incidence of households having a child with special health care needs, as the actual number is likely to be higher.)*

**Incidence of Needing Care While Waiting**

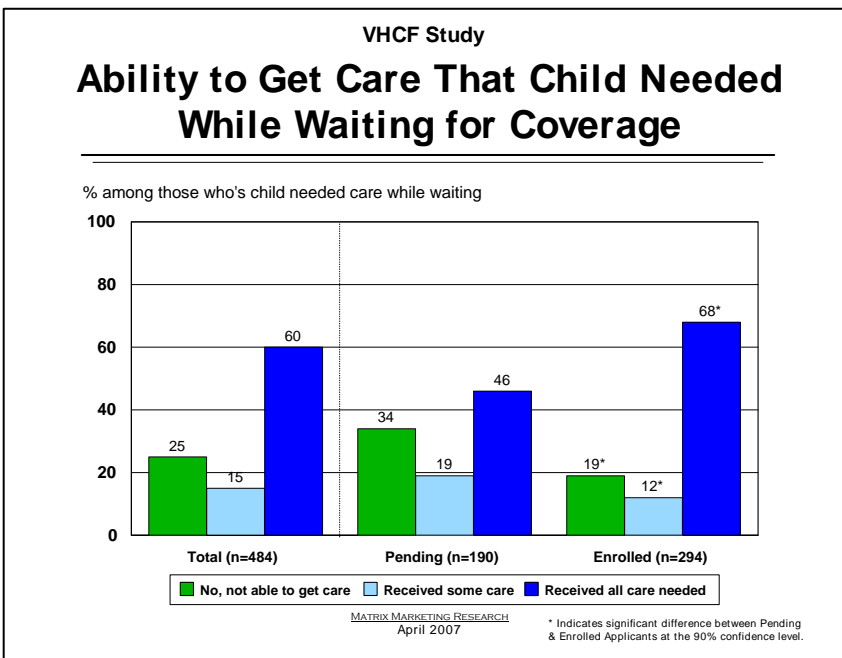
During the time they were waiting for their child's coverage to begin, two-thirds of adults whose child did not have another source of adequate health coverage available to them reported that their child did in fact need health care during the waiting period (65%).



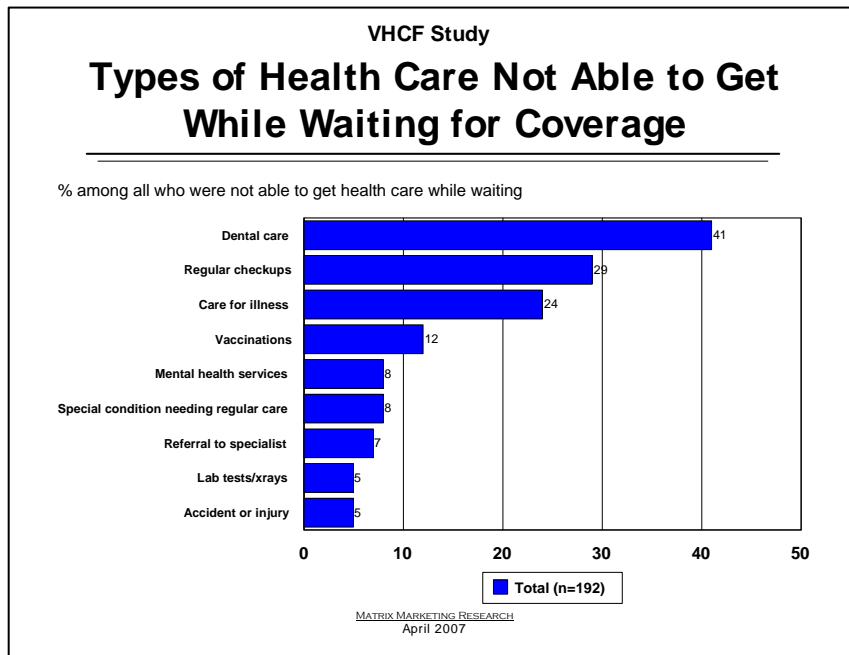
## Incidence of Being Able to Obtain the Care Needed While Waiting for Coverage

Among the adults whose child needed to obtain health care while waiting for their enrollment, 40% were not able to get all of the care needed. One-in-four parents say they were not able to get any of the care that their child needed while waiting for coverage.

Adults who have a child with a special health care need were significantly less likely to be able to obtain all of the care their child needed while waiting (54% were not able to get all care needed).



## Health Care Needs Not Met While Waiting for Coverage



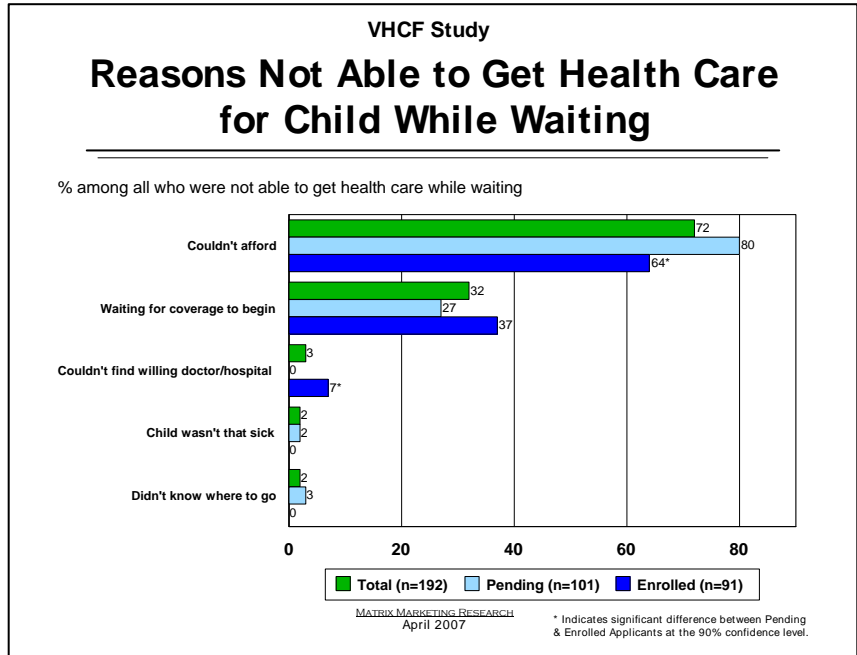
The most frequently reported types of health care that adults were unable to obtain for their children while waiting for their enrollment to begin were:

- dental care (41%),
- regular check-ups or physicals (29%),
- medical care for an illness (24%) and
- vaccinations, shots, or immunizations (12%).

Adults whose children were reported to have a special health need were significantly more likely to report that they were unable to obtain medical care for an illness (33% vs. 20%), the care for a special medical condition that their child receives on a regular basis (28% vs. 0%) and lab tests or x-rays (11% vs. 3%).

## Reasons for Inability to Obtain Care While Waiting

The primary reason given by those adults who reported that they were not able to obtain needed care is that they *couldn't afford it* (72%). The "inability to pay" reason was mentioned more than twice as often as the next reason mentioned (*waiting for coverage to begin*)(32%). A total of 3% said they *could not find a willing doctor or hospital*.

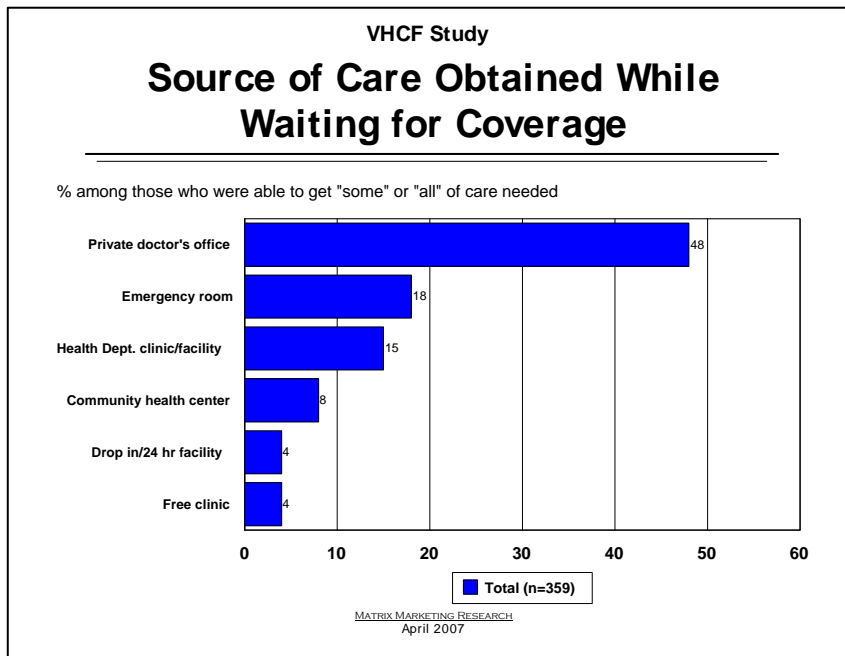


## Use of Emergency Room and Other Sources of Care Obtained While Waiting

Adults who needed to obtain health care for their child while waiting for their children's Medicaid enrollment to be approved said they most often took their child to a *private doctor's office* (48%).

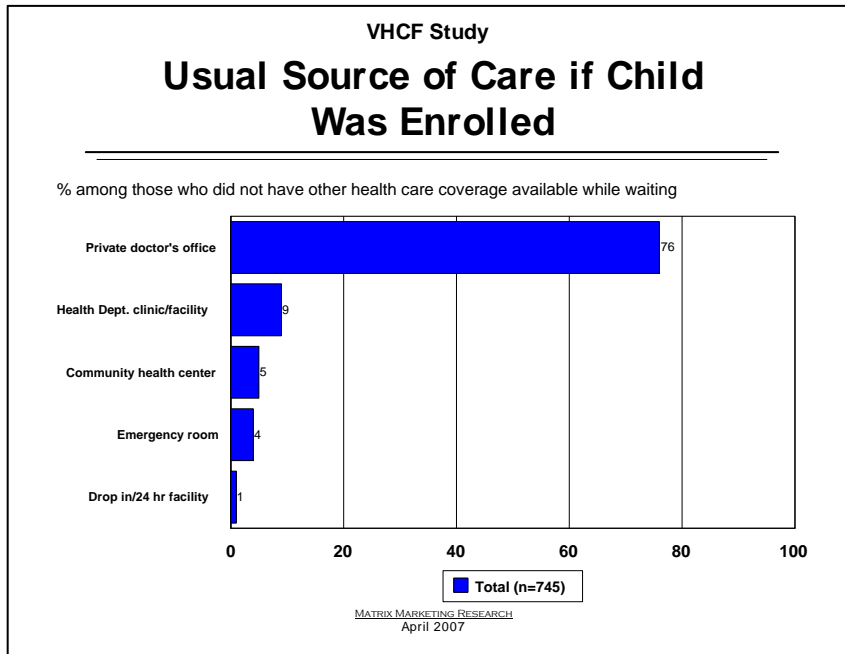
**Almost one-in-five took their child to the ER (18%).**

This contrasts with only 4% who say they usually take their children to the ER for care, when their children are enrolled in health coverage.



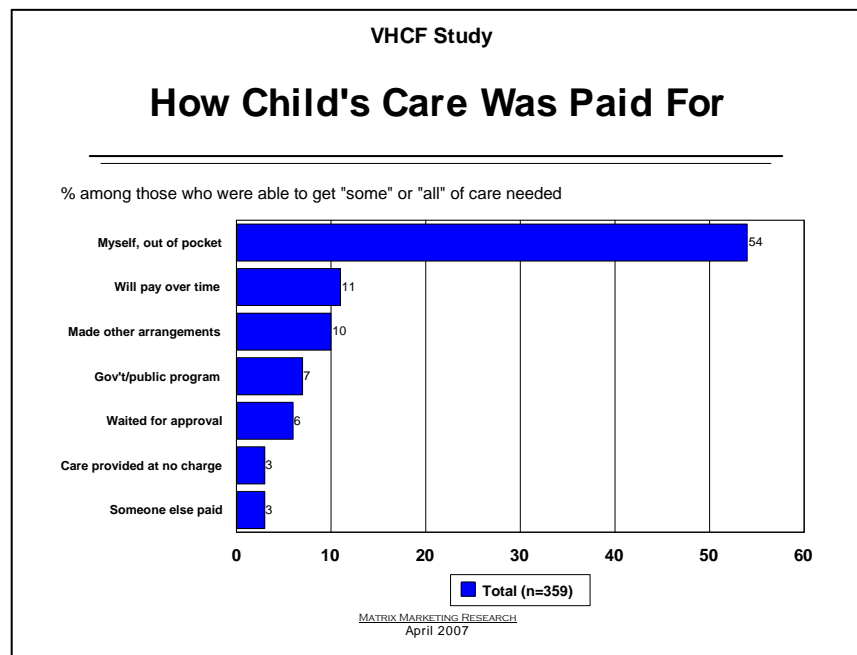
## Usual Source for Medical Care When Child is Enrolled

The most frequently reported source of health care, and where adults say they *usually* take their child when they *are enrolled* in Medicaid, is also a *private physician's office* (76%). This is the usual source by a very wide margin over all other possible sources measured in the survey. In contrast, approximately one-in-ten adults said their child's usual source of care is a *health department clinic or facility* (9%), while 5% mentioned a *community health center* or the *ER* (4%).



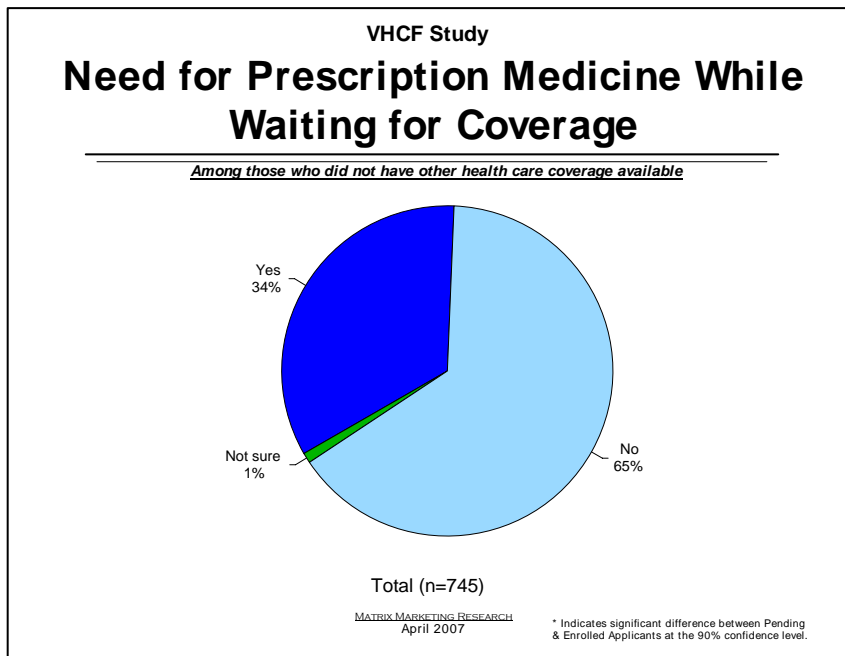
## How Care Was Paid For While Waiting

The majority (65%) of adults who were successful in obtaining health care for their child while waiting for the Medicaid enrollment paid for their child's care. Fifty-four percent (54%) said that they *paid for the care themselves*, out of their own pockets. One-in-ten said they *made arrangements to pay over time* (11%) or *made other payment arrangements* (10%). A total of 7% said the care was received as a government program or public program benefit.

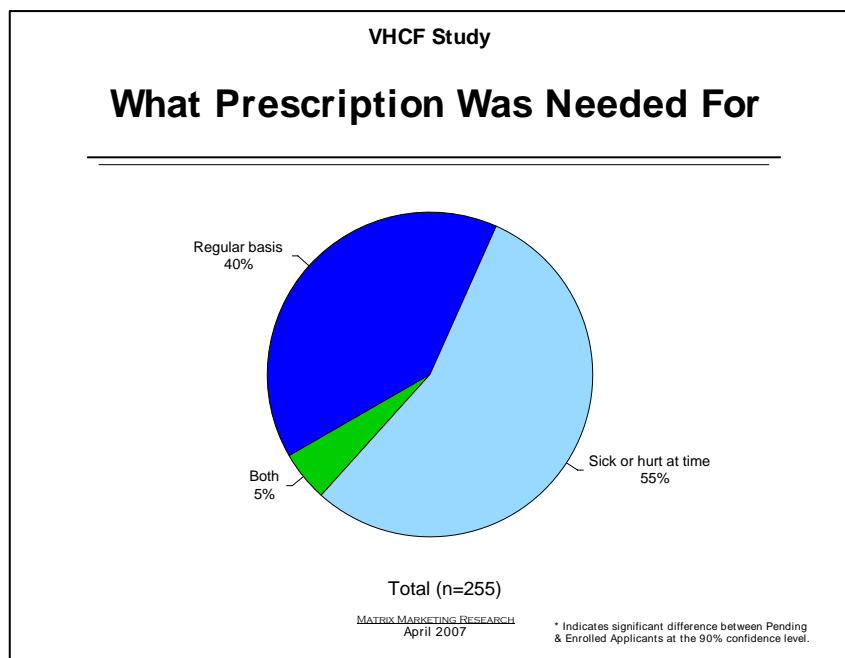


**Prescription Medications: 1 in 3 Children Needed While Waiting**

During the time they were waiting for their child's coverage to begin, approximately one-in-three adults said their child needed prescription medicine.

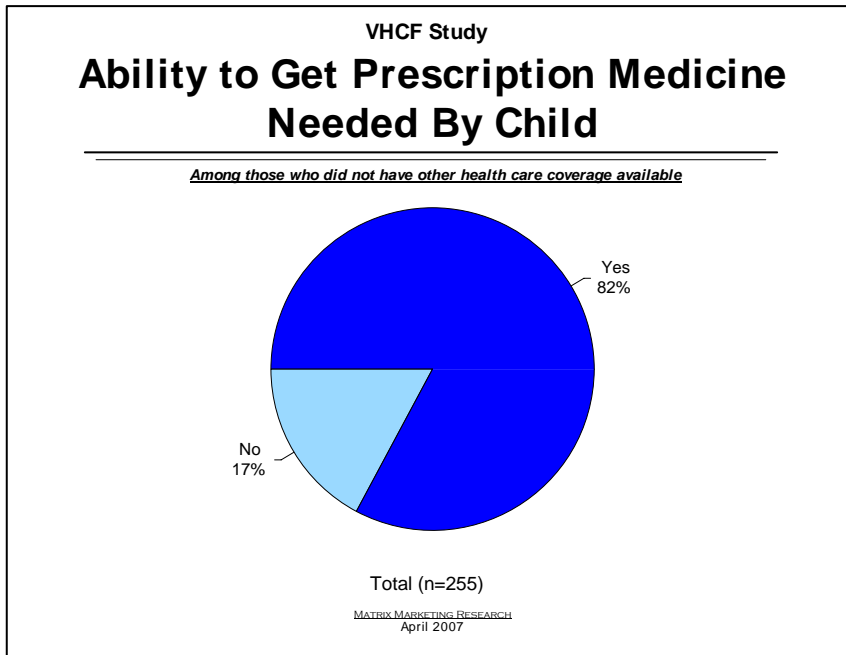


The prescription needed most frequently was for a medicine to treat a child who was *sick or hurt at the time* (55%). Many respondents (40%) also needed a prescription drug that their child was *taking on a regular basis* to treat a special need or condition that he or she already had. A small number of adults said their child needed a prescription for *both types of medicine* while waiting for enrollment (5%).



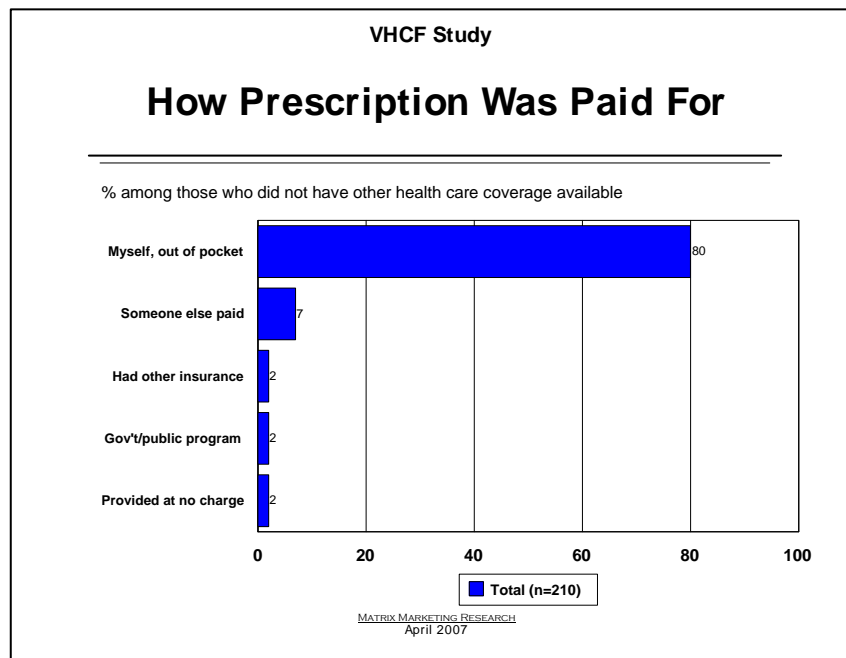
### **17% Unable to Obtain Prescription Medications While Waiting**

Among adults whose child needed a prescription medication while waiting for their enrollment to begin, there were 17% who were *not able* to obtain the needed prescriptions for their child.



### **How Prescriptions Were Paid For While Waiting for Coverage**

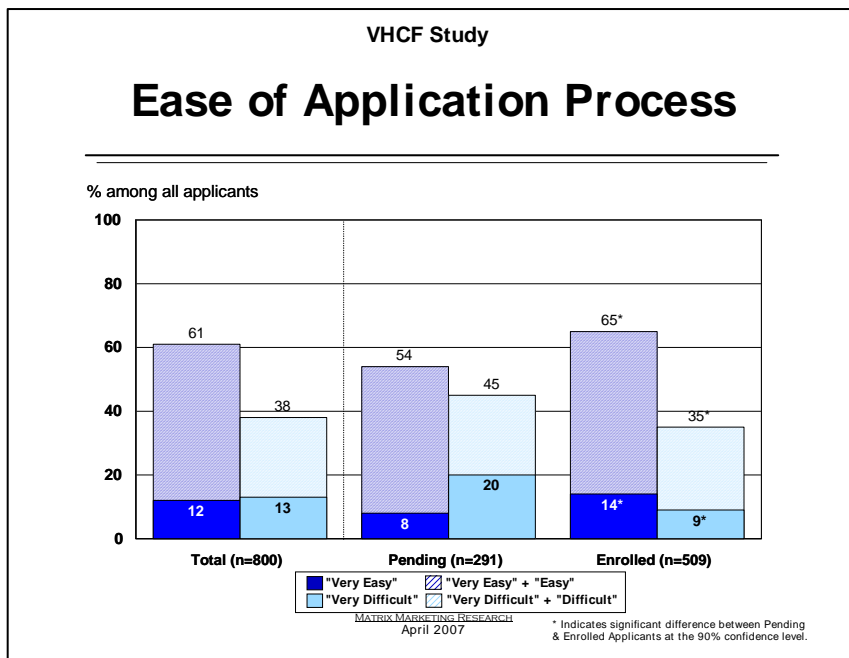
Among those adults whose child needed a prescription medication while waiting for their enrollment to begin, 80% said they paid for the prescription *out of their own pockets*; 7% said *someone else paid for it*.



## Ease of the Application Process

Adults were asked to evaluate the entire process of applying for Medicaid. Ratings were made using a four-point scale that ranged from *very easy* to *very difficult*.

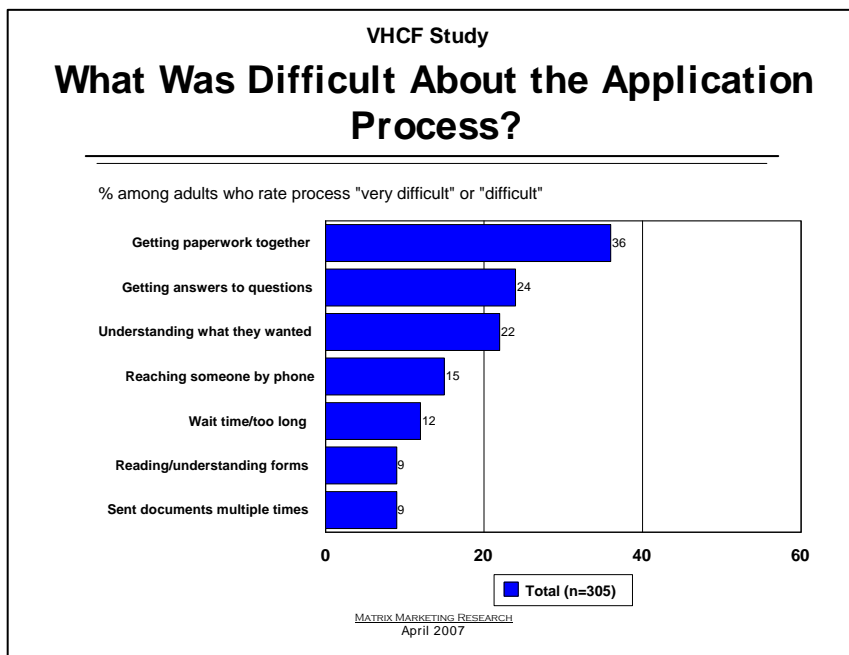
A sizeable portion of adults (38%) rated the application process as being *difficult or very difficult*. In a similar survey conducted in 2004, only 8% of respondents reported the process to be difficult.



## Reasons Why Enrollment Process Is Rated “Difficult”

When asked what was difficult about the process, the leading reasons given included *getting all necessary paperwork together* (36%), *getting answers to questions* (24%), *understanding what information was required* (22%) and *reaching someone by telephone* (15%).

Other complaints were that the *wait time is too long* (12%); *problems reading or understanding the forms* (9%) and being required to *send the documents multiple times* (9%).



### **Children in Survey Were Citizens**

Nearly all children in the survey (97%) were born in the United States. The majority of the children (69%) were born in Virginia. All households were asked the name of the hospital where the subject child was born. More than 300 individual hospital names were provided by the 800 respondents of the survey. A total of 93% recalled the hospital name. Only one respondent (0.1%) named a hospital outside of the United States.

### **Phone Number to Call for Assistance**

As a courtesy at the conclusion of the survey, all respondents were offered a number to call where someone could answer any questions they might have about their child's application.

A total of 67% of respondents with pending applications requested the number, and 44% of respondents whose children had been enrolled requested the number.

## CONCLUSIONS

Thousands of Virginia children are losing health coverage and delaying needed medical care due to inability to show proof of U.S. citizenship and identity as required by federal law aimed at illegal immigrants. In the first nine months since the new rules took effect as many as 20,000 children in Virginia have gone without health coverage because they did not have the required documentation.

The new requirements have also had a significant, negative impact on access and quality of care. Because of the new requirements, enrollment and re-enrollment in Medicaid took much longer than it should have for thousands of children. While waiting for their health coverage to be approved, Virginia children have gone without needed medical care, including care for illness or injury, immunizations, dental care and prescription medications. Overwhelmingly, these are U.S. citizen children, born in U.S. hospitals, mostly in Virginia.

The state and local systems set up to process Medicaid applications have also been affected. Processing at both the CPU and in local departments of social services is taking much longer, even for those cases in which all of the documentation **is** provided.

The new requirements to provide original documentation have undermined Virginia's successful efforts to simplify and streamline application procedures by offering mail-in, faxed, and electronic applications. Many families are understandably reluctant to mail their child's original birth certificate (*if they even have one*) to their DSS office, and getting to the office to present it in person during regular business hours presents many additional barriers. Securing out-of-state birth certificates is costly and time-consuming. Virginia has recently implemented a procedure for requesting and paying for those on behalf of families. However, this remains a delaying factor.

Virginia had made great strides over the last five years in enrolling eligible children in its FAMIS Programs (*Medicaid and SCHIP*). Since January of 2002, more than 150,000 previously uninsured children have been enrolled in health coverage, greatly reducing the number of uninsured children in the Commonwealth. In the year prior to July 1, 2006, we saw an average monthly increase of about 1,400 children per month in the two programs.

Now, that impressive progress and the health of thousands of Virginia's most vulnerable children are threatened. Prior to the implementation of the citizenship and identity requirements, there were no data to suggest that ineligible non-citizen children were enrolling in Virginia's Medicaid program. Now, however, data demonstrate that U.S. citizen children in Virginia are losing health coverage.

## **Technical Appendix: Methodology**

### **Survey Technique**

Matrix conducted a telephone survey among a random sample of parents and guardians who had applied for Medicaid for their children in the months of July 2006 through January 2007. Interviews were conducted by professional survey interviewers supported by an advanced Computer Assisted Telephone Interviewing (CATI) system.

### **Sample Size and Maximum Sampling Error**

The survey sample was drawn from a pool of 2794 households who filed an application for Medicaid at the CPU between July, 2006 and January 2007<sup>3</sup>. These applicants had been determined to be likely eligible for Medicaid, based on income verification provided. Cases were excluded from that pool if the children were actively enrolled in FAMIS (SCHIP) and were being evaluated for renewal; were subsequently enrolled in FAMIS; or were denied eligibility. All applicants reported being a U.S. citizen.

A total of 800 interviews were completed; 509 interviews were completed among adults whose children were recently enrolled in Medicaid, (*application submitted after July 1*), and 291 among adults whose applications for their children's Medicaid were still pending at the time of the interview.

<b>PENDING and DELAYED APPLICATIONS SURVEY</b>		
<b>Statewide VIRGINIA Sample</b>	<b>Completed Interviews</b>	<b>Margin of Error</b>
Enrolled at the time of the interview	509	±4.3%
Application still pending at time of interview	291	±5.7%
<b>TOTAL:</b>	<b>800</b>	<b>±3.5%</b>

### **Note on Program Names**

The Medicaid Program was also referred to in the survey questionnaire as FAMIS Plus. This was done to ensure clear communications with applicants and enrollees in light of the continued widespread use of *Medicaid* by some parent-guardians in Virginia as the name of their child's health insurance program.

### **Timing**

The average length of a single interview was approximately 12 minutes. Interviewing was conducted from February 22 through March 18, 2007.

<sup>3</sup> Applications for Medicaid in Virginia may be made at both the Central Processing Unit and through local departments of social services (LDSS). Since each LDSS is locally administered, individual Business Associate Agreements would have been necessary in order to draw from their applicant pool and comply with the requirements of the Health Insurance Portability and Privacy Act (HIPAA). In order to ensure a large statewide sample in a timely manner, applications were drawn from the CPU.

### **Demographics – Survey Respondents**

The population of adults surveyed was primarily Caucasian (43%) or African-American (39%), and predominantly female (89%).

<b>Ethnicity</b>	<b>Total</b>	<b>PENDING</b>	<b>ENROLLED</b>
Caucasian	43%	40%	45%
African-American	39	42	38
Hispanic / Latino	7	9	6
Asian-American	4	3	4
Other	7	6	7
<b>Base:</b>	<b>800</b>	<b>291</b>	<b>509</b>

<b>Gender</b>	<b>Total</b>	<b>PENDING</b>	<b>ENROLLED</b>
Male	11%	14%	10%
Female	89	86	91
<b>Base:</b>	<b>800</b>	<b>291</b>	<b>509</b>

### **Demographics – Children**

The ethnicity of the applicant children reflected that of the adult survey respondents, with 43% Caucasian, 39% African American, and 7% Hispanic/Latino.

The majority of applicant children were school-aged (6-15 years) with another 28% age 5 or younger.

<b>Age of Applicant Child</b>	<b>Total</b>	<b>PENDING</b>	<b>ENROLLED</b>
0 – 24 months	13%	11%	15%
2-5 years	15	14	16
6-15 years	59	60	58
16-18 years	12	12	12
19 years	1	2	0.2
<b>Base:</b>	<b>800</b>	<b>291</b>	<b>509</b>

## **Development of the Survey Questionnaire**

To ensure that VHCF's informational objectives were met by the study, and that key issues were accurately explored in a clear and understandable manner, the survey questionnaire development process was appropriately lengthy. Multiple drafts were exchanged over a period of several months between VHCF, DMAS, and Matrix, and integrated with input provided by DMAS eligibility policy and application experts.

## **Drawing a Representative Sample**

To complete the required 800 interviews, Matrix called into a population of 2,794 household listings (or 4,943 children) that was provided by DMAS from its data base of applicants. The list was compiled from applications made from July 1, 2006 through January 31, 2007 through the Central Processing Unit.

To ensure that the final sample of 800 would be a representative cross-section of the total list population, the list was randomly sorted to avoid order bias. Additionally, each listing was dialed up to six times before being abandoned. This procedure is designed to ensure that each listing has an equal opportunity of being included in the final sample, and that sufficient attempts are made to contact a respondent at the listed household.

The ratio of household listings available to the number of completed interviews was 3.5-to-1. By current industry standards, this is a low ratio. More common are ratios of 15-to-1 and 20-to-1. With a limited number of listings available, all available listings had to be called multiple times in order to complete the 800 needed interviews. While a low sample ratio generally has an impact on cost and productivity, it does not affect the final results of the study.

## **Cooperation Rate**

The cooperation rate for this study was 88%. The cooperation rate is calculated by dividing the total number of completed interviews by the total number of respondents reached by telephone. A cooperation rate of 88% is a relatively high number by current research standards. It reflects a high willingness among respondents to participate in the study, which in turn enhances the validity and representativeness of results drawn from the sample.

$$\text{Cooperation rate} = 800 \text{ divided by } 914 = 87.5\%$$

$$800 = [800 \text{ completes}] \text{ divided by}$$

$$914 = [800 \text{ completes} + \text{initial refusals (41)} + \text{respondent terminates (34)} \\ + \text{requested to be added to Do Not Call list (39)}]$$

A copy of the final dialing report produced for the VHCF surveys is provided below.

<b>VHCF Survey Dialing Report</b>	
Interviewing Start – Finish Dates	2/22/07 – 3/18/07
Average Completed Interview Length	12 minutes
Incidence of Qualified Respondents	71%
<b>Dialing Results</b> <i>(shown are actual numbers)</i>	
<b>Completed Interviews</b>	<b>800</b>
Business/Residence	24
Disconnect	450
Privacy Manager / Blocked Number	6
Fax/Computer Tone	21
Language Barrier	257
Not Qualified – Wrong number	186
Not Qualified – Did not submit app/Not still pending/ Refused to say if child was approved	37
Not Qualified – Has no qualifying child	22
Over Quota – A household with an enrolled child was reached when a household with a pending application was needed	90
Interviewer Terminate	1
Respondent Terminate	34
Initial Refusal	41
Requested to be added to DNC list	39
Respondent Not Available	2,253
No Answer	4,091
Answering Machine / Voice Mail	4,635
Busy Signal	516
<i>Total Dialings</i>	<b>13,503</b>

### **Quality Control of Data Collection**

Quality control of the data collection process (i.e., telephone interviewing) consisted of five separate elements: 1) CATI programming of the questionnaire, 2) interviewer training, 3) pre-survey test calls, 4) live monitoring during the survey, and 5) interview validation call-backs.

#### **CATI Programming of the Questionnaire**

The final drafts of the two survey questionnaires used in the study were programmed in ACS-Query Computer Assisted Telephone Interviewing (CATI) software. CATI programming completely automates the questionnaire, and ensures that only valid answer ranges are used and that question skip patterns, rotations and special probing instructions are provided automatically to the interviewer.

CATI sharply reduces interviewing error rates and provides data collection of the highest accuracy possible.

### Interviewer Training

Telephone interviewers are trained in the fundamentals of market research in a classroom environment. Following the classroom phase, each prospective interviewer must take a written exam covering key research terms and techniques. Those earning a passing grade begin a three-week on-the-job orientation period. During this period, interviewers go through a formal certification process, ensuring each is aware of and practices sound interviewing techniques.

Trained and well-experienced interviewers were used for the VHCF survey. All who were assigned to the project attended a question-by-question training session, plus received daily shift briefings, including a short refresher review on the topic of the day, keeping them always in top form.

### Pre-Survey Monitoring of Test Calls

Matrix pre-tested the questionnaires among a small sample of 15 households drawn from the original sample listings. Pre-testing is especially critical whenever the subject matter or terminology of the survey is potentially confusing or unfamiliar to survey respondents.

The test interviews were monitored “live” by the Matrix project director via silent listening equipment. The project director was able to listen to both sides of each test call for wording or question flow problems, and focus on those that occur with more than one respondent. The questionnaire was revised based on these tests prior to committing the full project to the field.

### Live Monitoring During the Survey

Matrix requires that a minimum of 15% of calls made on each project be live-monitored by phone center supervisors. The silent monitoring system allows the monitoring supervisor to have full, non-intrusive access to an interviewer’s questionnaire while the interview is in progress. Monitoring is a spot-checking process designed to motivate interviewers to perform their calling as specified in training.

### Interview Validation Call-backs

Ten percent of all completed interviews were validated during each interviewing shift, usually within 30 minutes of the original interview. A field supervisor made the validation call-back. He or she asked to speak to the person interviewed by first name, explained that the call is to verify a few answers, then asked several previously-answered questions as a means to confirm with certainty that the interview was completed with that person.

Validation call-backs are also a spot-checking process designed to motivate interviewers to perform their calling as specified in training.

## **Sample Weighting**

For most telephone surveys, there will be differences in the sample distributions of certain key variables (i.e., gender, age, or region), and the distributions found in the study universe or population. Often these differences are deliberate, in order to meet certain minimum sample size quotas; other times they are due to limitations of the available quantity of sample or the nature of the people being surveyed, their willingness to participate or the topic or length of the survey.

Two options available to correct these differences are increasing the budget to increase the calling effort needed to reach difficult or hard to find subjects, or to employ a traditional and widely accepted methodology called sample weighting.

The VHCF survey had such a need for weighting based on the racial characteristics of the final sample, as well as the geographic regional profile.

Differences in the racial distributions were due mainly to a lower-than-needed rate of participation by Hispanics. Differences in the regional profile, however, were deliberate, and were made in order to produce equal sample sizes in each of four geographic regions of Virginia. The regional quotas were set to prevent the larger East region from dominating the sample, and to provide sufficient statistical confidence in the smaller Western region of the state to allow reliable region-to-region comparisons.

The final data file was statistically weighted by Matrix prior to tabulation based upon the current race and region distributions found in the DMAS population listings. Both the list proportions and the survey sample proportions are shown in the table below. The sample weighting procedure utilized by Matrix corrected the sample proportions to match the population proportions.

While not shown here, the actual weighting was done for each data “cell”; that is, weighting factors were determined for “North/White”, North/Black” etc, for a total of twenty individual weighting factors for all combinations of race and region.

<b>Distribution of Sample Provided by DMAS</b>					
<b><u>RACE</u></b>	<b><u>List</u> (Number of Children)</b>	<b><u>Unweighted Survey Sample</u></b>	<b><u>REGIONS</u></b>	<b><u>List</u> (Number of Children)</b>	<b><u>Unweighted Survey Sample</u></b>
<b><u>White</u></b>	37%	43%	North	22%	25%
<b><u>Black/A</u></b>	39%	39%	Central	27%	25%
<b><u>Hispanic</u></b>	15%	7%	East	33%	25%
<b><u>Asian</u></b>	3%	4%	West	18%	25%
<b><u>Other</u></b>	6%	8%			
<b><u>TOTAL</u></b>	100%	100%		100%	100%
<b><u>Base:</u></b>	<b><u>4,943</u></b>	<b><u>800</u></b>		<b><u>4,943</u></b>	<b><u>800</u></b>

### **Limitations of Telephone Surveys**

Any survey based upon a scientific sample of any population is subject to certain limitations regarding how the results can be applied to the population being surveyed. Aside from the usual caveats associated with sample size and statistical confidence intervals, there are two limitations of the survey to be noted.

- a. Medicaid applicants who do not have telephone service were not included in the survey sample. These applicants represent approximately 4% of the DMAS-provided listings.
- b. Due to limited resources, applicants who do not speak English were not included in the survey sample. These applicants represent approximately 18% of the households contacted by telephone during the survey.

[Language barrier (257)] divided by [Language barrier (257) + Completed (800) + Interviewer Terminate (1) + Respondent Terminate (34) + Not Qualified (245) + Over Quota (90)]

Incidence = 257 divided by 1,427 = 18.0%

## ACKNOWLEDGEMENTS

The Virginia Health Care Foundation would like to acknowledge the following agencies and organizations for their assistance with this study:

- The Virginia Department of Medical Assistance Services (*DMAS*)
- The Virginia Department of Social Services (*DSS*)
- ACS, Inc. / FAMIS CPU/ FAMIS Plus Unit
- The Virginia League of Social Services Executives
- The Virginia Poverty Law Center
- The Loudoun County Department of Family Services
- The Chesterfield/Colonial Heights Department of Social Services
- The Virginia Beach Division of Social Services
- The Russell County Department of Social Services
- The Tazewell County Department of Social Services
- Matrix Marketing Research
- Georgetown University Health Policy Institute
- The Urban Institute Health Policy Center