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The Medicaid Proof of Citizenship Requirement: Lessons for California from the Experience of Other States
Part II
California HealthCare Foundation
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MIKE FOGARTY: You could have documented your citizenship in order to get the meal today [laughter]. You got something in your wallet? If you do, it's your voter registration card. The U.S. Constitution requires that you be a citizen of these United States in order to vote. I learned that from a border guard, Mr. Smith, between Detroit, Michigan and Windsor, Canada in about 1974.

When he asked me to document my citizenship and I offered my driver's license and my state employee identification and my social security card and everything else I could, credit cards, whatever I could find in my billfold, none of which passed muster, after which he explained to me that if I had my voter registration card and an ID, that would suffice. I was relieved to know that and you'll be glad to know I have that in my pocket. However, the federal government will not accept that in order to enroll in Medicaid, which I find interesting [laughter].

You know that the issue is not whether we have illegal immigrants in our country and whether those illegal immigrants are getting things that maybe they shouldn't get. That's not the issue. The issue is have we created a barrier for citizens of this country and legally admitted non-citizens to access to Medicaid.

What Donna did not tell you is that my bio starts with

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my very best and first job, which was as a county caseworker, social worker in Pottawatomie County in Shawnee, Oklahoma. It's where I got to meet these people. It never dawned on me in these 38 years that I would be required as an employee of the government to demand documentation of citizenship in order to provide services. For those of you who are still out there in that world looking those people in the eye, thank you for doing your job and I am sorry that it includes that demand.

I will tell you that as a lawyer and a social worker, my life is full of dilemmas [laughter] every day and my lawyer, when confronted with this reality, said enforce the heck out of this law, make it as tough as you can possibly make it so you can demonstrate its absurdity and in that way, hopefully, overcome it. But of course, my social worker said no, no, no, you got to figure out how to get these people past this barrier. So we're going to focus on that today and I'll let you do with what you will the notion of what we might do to make a case for its repeal.

Oklahoma was, as Virginia, in the midst of a very successful campaign to get both children and adults enrolled in its Medicaid program. Oklahoma legislature passed a few months before the enactment of SSI an expansion of eligibility up to 185-percent of federal poverty for all children and pregnant women in the state of Oklahoma and they did that in response to a crisis that 25-percent of the million children in Oklahoma,

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250,000 in 1996 and seven and no coverage for health insurance.

Happily the congress enacted SCHIP, which gave us some enhanced federal revenue and made it possible for us to move even more quickly, but unlike Virginia, SCHIP was an expansion of Medicaid in Oklahoma. So when I talk about the Sooner Care program or Medicaid, it includes both Medicaid funded as well as SCHIP-funded.

We did the classic things enthusiastically. We reduced the application from some 17 pages to one page front and back. We eliminated face-to-face interviews, which had been a historic and consistent requirement in Oklahoma. We eliminated a six-month certification in favor of a 12-month certification. We did aggressive outreach specifically aimed at children through schools, churches, community health, and other programs and we eliminated the asset test, which was a big item in Oklahoma not because it changed anybody's results in certification. It just delayed it.

If you came to me as a social worker in the county office and said, yes I have a life insurance policy, that immediately put 45 to 60 days in the process because then I had to get the form to release the information, send it to the health insurance company, find out what the cash value was, which never made anybody ineligible. It just delayed the process. Those were the kinds of things we were looking for to eliminate.

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The other thing we did is we changed the way we talked about it. You've heard me say Medicaid more times in the last minute than I've said probably in the last six weeks. We don't have a Medicaid program in Oklahoma. We have a Sooner Care program. It's intended along with many other changes. We enroll people. We don't certify them. They are qualified. They're not eligible.

It is a program that has, by policy, tried to separate itself from the welfare system. I don't know whether that's a reality in California but I expect it is. The resistance of people to apply even for services around health issues because frankly they just don't want to make the connection with the welfare system. It's a real reality in Oklahoma.

Here's the measure of our success. We've plotted the growth. I didn't go all the way back to 1997 when there were 160,000 children enrolled and compare that with this last November when there were 420,000 children enrolled but this goes back to about 2003.

As you can see and this just plots fiscal year '03 starting with July at the bottom. You see consistent growth through every year up and until state fiscal year '08 when for the first time and even longer than this, for the first time in ten years, we saw the downward trend. We saw it in Virginia. We saw it in Oklahoma.

Now I will tell you Oklahoma didn't implement with

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enthusiasm in July '06 this new law. we drug our feet and the social worker won. So we delayed implementation as long as possible but the lines crossed in January of '08 when, for the first time in over ten years, we had fewer people enrolled in Sooner Care than we had in the previous year. I wonder why.

It just happened that December of '07 was the first month that people were terminated from the program as a result of failure to document. So although we implemented the law, we just failed to enforce it for a while. Once we did that, the numbers started rolling in.

This is an important document only in that it is absolute proof that this has less to do with disenrolling people who might not be legally residing in the United States than it does in just creating a barrier.

Your attention please to the far right where you'll see that when we break out the total Sooner Care population in Oklahoma by race or ethnicity, we have one-percent Asian, ten-percent Hispanic, 13-percent Native American. We'll talk about that a little, 16-percent African American, and 60-percent Caucasian.

Then beginning on the far left, you will see each month the racial identity or ethnicity of those who were terminated that month as a result of failing to document their citizenship. I think the widest spread we have in variation comes along in April when we had 19-percent of the population

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terminated were African American and their overall participation is 16 but three-percent is the highest one you'll find and often it's the same percentage.

In other words, it should come as, I suppose, no surprise, that we would not expect many Native Americans in Oklahoma not to be U.S. citizens [laughter]. We frankly would not expect many African American residents of Oklahoma not to be U.S. citizens. Well, the point being this is about a random barrier to enrollment. I suggested we could have seen an impact much like this if we had said you must tell us the maiden name of your maternal grandmother and if they know that, how about the birth date?

It would act as any random barrier to enrollment. It very effectively reduced the caseload, which is frustrating because I've got members of the Oklahoma legislature that were celebrating the fact that our expenditures were down. Thankfully, not a majority.

This is really just a similar breakout that supports the notion that it's a barrier. It's a little surprising frankly because you would not expect there to be as high a percentage, I think, of children, at least I wouldn't. I would have thought that those documents would have been more easily obtained but that doesn't show up in the statistics. So it was across the board.

Now one of the things that you have to do if you were

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once a county a worker and got to see these people and no longer do that, you have to get the real folks on the screen. In April, there were 7,156 people terminated for failure to document. One of those was a 51-year old woman receiving therapy for breast cancer.

In May, there were 5,572. One of those was a nine-year old boy who had been known to the system since shortly after his birth who suffered from bipolar. One was a 39-year old Native American. This was one of 4,873 terminated in June and I apologize for putting you through this. It just helps me to put the, these are not made up. These are real folks and I have pages but I didn't put them all on slides.

We have one lady that was in our program to care for pregnant women, high-risk, she's 25-years old. She was about 33 weeks when she lost eligibility. Then in August, there were over 5,000 people terminated from the program including a 19-year old homeless young lady who had no way to navigate a system required to document her citizenship.

Did I say that patience was not one of my [laughter]. Sorry Ingrid. See what my reaction to it not moving is just to keep pounding on the button. So if you just go back a ways, it'll finally get back to it.

INGRID AGUIRRE HAPPOLDT: There we go. It's going to be déjà vu by the time we get there.

MIKE FOGARTY: One more. There it is. Okay. Now

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[laughter], it likes my 19-year old and I'll tell you what, I like her too. I'm worried about her. I am worried about her. This is a chart that plots the totals for all those months that I've just given you and for each one of those months, I could give you many, many specific cases and if you'd like to have more of those, if you'll let me know, I'll be glad to get them to you.

This doesn't have the total. These numbers are people, 58,535 people have lost eligibility in Oklahoma Sooner Care program as a result of their failure to document. Now some folks celebrate the fact that about 45-percent, 27,500, have managed at some later date to work through that, most of which were done with the aggressive assistance of those folks who are out there in the counties and are trying to figure out a way to help that 19-year old but that means about 45-percent of those have managed to get back on.

So more than half of that 58,000 are still out there with no coverage not because they're not eligible but because they have not, for one or more of many reasons, been able to navigate the system.

Our efforts continue. I've learned some things today, I'm happy to report, about some things that states are doing to try to overcome it. I wanted to highlight a few because I really know that this is not a rally around this issue. This is you trying to discover what we have successfully done to

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overcome it.

We have a data match with electronic payment of new, I have this theory that if I can show electronically that I paid for the birth of that child in the Oologah, Oklahoma hospital, they're citizens sure enough. So I use that to document. Don't have to ask for documentation. I will tell you, I won't try to go back you'll be happy to know but you will notice on your slides on the monthly breakout that about three months ago, the Native American number went from 13-percent to zero.

My staff don't want me to do this with the film running but I will tell you the reason that happened is because in spite of the federal government's refusal to acknowledge it, as the state whose name means home of the red man, as the state who has 39 federally recognized tribes, we just don't have the stomach to challenge the citizenship of someone who can document their tribal membership. So if they can document membership in a tribe, they're good to go [laughter].

I'm all about complying with the law [laughter]. I mean you know what a Sooner is right? Sooners are the folks that snuck across the line before the gun went off so that they could stake out a claim on land they wanted back in 1889. So it's about working around those rules [laughter]. I mean okay.

Insure Oklahoma is one of the, I mentioned the one out of five, I may have said that one out of five Oklahomans today have no health insurance. Nineteen-percent of them are kids,

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80-plus-percent, 81-percent are adults. We have a program that subsidizes a premium program that we call Insure Oklahoma and one of the things we did for the now 13,000 people in that program is to accept the affidavit of their employer.

When you look at that list of acceptable identifications, I don't know how many of you have experienced it but if you are an employer, you're required essentially to have exactly that same kind of documentation in your file in order to legally hire that person. So if an employer will sign that affidavit that they do, in fact, have that documentation, that's good enough as well.

The Eve System, I expect you are familiar with. It has some potential. We've not really implemented it. We have just bought the software. This is a system that your vital statistics folks can hopefully apply so that they can retrieve information from your vital statistics resources electronically.

We do other direct health department, the health department in Oklahoma is the agency that maintains the vital statistics. So we do data match with them. Somebody made the point a while ago that if you can avoid having to even ask the question because you've already got it in file electronically, go for it.

We obviously use the federal SSI and SDX data match and then finally, and this is the most important, again it's just

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going the extra mile or two or five or ten to help that 19-year old or that 51-year old or that 25-year old pregnant woman navigate the system, whatever it takes. We don't have all the money in the world. In Oklahoma, it costs $15 to get a birth certificate.

My four children and their mother and I would pay $90 to verify our citizenship via going to the health department to get birth certificates. I've got an awful lot of folks that are enrolled in Sooner Care that don't have $90 in their pocket to do that for a family of six but creative ways to get the job done and this works most effectively for those that don't have avenues of data match, don't have local information and have to go out of state.

So that's where we are and thank you so much for the invitation. I almost always get in trouble when I come to California. Stan mentioned I got Dennis Smith to admit that he could not answer the question what value is there in a photo ID that's mailed in [laughter]. That question was posed in San Francisco right down the street. So here I am. I can't wait to see how it plays but thank you very much for the opportunity not only to share with you but could learn from it [applause]. Thank you.

DONNA COHEN ROSS: Again just one more time to join me in thanking both Judith and Mike for their presentations [applause] and for everything [applause]. As I said, we did get

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a little extra time and I do want to take as much time as we want to talk with Mike and Judith and ask them some questions about what they've shared, but I've been asked to sort of do a little additional discussion at the end of their presentations to just share a little bit from some states that we wish we could have had come along but couldn't join us.

I'm not going to go over this in a lot of detail but there's a couple of points that I want to make that I think actually reemphasize what we've already heard. So let's see. Oh look at that. Okay.

Wisconsin is a state that has done a great job in terms of collecting data and reporting it to help tell the story and the Wisconsin experience actually emphasizes something that Judith mentioned in her presentation.

All states have codes that you all use to kind of indicate why somebody is either pending or gets terminated or delayed or whatever but sometimes those codes are very broad, sometimes even catch-all categories and so there weren't very many states that had a separate code that helped tell you this person's application was delayed or denied because of this very specific reason. But Wisconsin actually put into their coding system a separate code to indicate that the person didn't have citizenship documentation and a different specific code to indicate that it was identity that was lacking.

They've continued to use those codes very, very

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faithfully to track the eligible people who have been denied or delayed coverage. What they found was that two-thirds and this is every month, it just sort of repeats this pattern the same way Mike has shown that the patterns get repeated. Two-thirds did not have ID documents versus 20-percent that didn't have citizenship.

So part of what their data helps to show is that people can document their citizenship. It was the ID piece that was a problem. When you think about it, people said well why don't people have ID? They might have ID but they might not want to part with it through the mail as Mike has pointed out. So having these specific codes and being very faithful to using them really does help tell the story and Wisconsin has done a really fine job with that.

The other thing and the Center on Budget did this, again we were really challenged at the beginning to prove that the people who were losing coverage were not actually undocumented immigrants trying to get Medicaid fraudulently. It was very hard to do that. So we came up with different ways of kind of backing into that conclusion.

Again, the Wisconsin situation helped because they had those codes, but the other thing we looked at was from, we looked at programs that serve similar populations, food stamps being one of them, and we looked at— and this again was in Wisconsin, what happened to food stamp participation during

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that same time period.

When Medicaid dropped, food stamps actually grew and the only thing that was different about Medicaid in that period of time was the implementation of citizenship documentation. So we kind of used that to help talk about why it really could only be one thing.

Kansas is another state that has done a really good job in keeping track of this. I wanted to mention Kansas again because of something Judith mentioned and also Mike. They reported up to about 20,000 people who had lost coverage early on in this process but really very fervently believed that once people got help to get their documents or help paying for documents paying from another state that people would come back in. They'd get the help from eligibility workers to help navigate and work out these kinks and low and behold, we would restore the losses that were sustained. That didn't really happen.

It happened for some people, again like Oklahoma, about half but about half the people who lost coverage are still out there. That is reported in June 2008. So there's a serious loss and I think we have all found with red tape and frustration that families can easily lose faith with a system that doesn't appear to be on their side. That is what I think has happened to some extent, in this case and I wanted to just again reiterate that and reemphasize that.

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This is what the Kansas Senate Majority Leader, Derek Schmidt, who's a Republican from Independence, Kansas had to say about this may be helpful right after lunch. This policy and mandates is something like trying to push a wet noodle up a hill with your nose. I don't know how he knows that [laughter] but it's something to picture if you want a laugh but basically, his take is that state taxpayers are picking up the dollars and cents cost of a failed federal policy. Well it hasn't failed yet because we're still with it but it's something to think about.

There was one other piece though that I wanted to mention because we also looked at three states and the distribution based on race and ethnicity, what happened to kids. Virginia was one of the states that we looked at as was Kansas and Alabama.

The overall message here was that whereas some people believed or predicted that the children who would be losing coverage would be Hispanic children, Latino children because so many of them were not properly on the program. Low and behold, that's not really what happened because what was going on was that primarily the children losing coverage were children who were citizens in the states that we looked at, again Alabama, Kansas, and Virginia.

We found that by and large, the children who lost coverage were mainly children who were African American and

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Caucasian. In some cases, Virginia's one, the enrollment of Latino children actually increased during this period following implementation. People said well gee, how's that? Why is that?

So we have some thoughts from actually a former colleague of Judith, Shelby Gonzalez, who worked with a really fine outreach program in Virginia through Anova Health System and she was asked actually by the Washington Post to kind of give her thoughts on why this was the case. Here was her explanation and I'd be actually interested in knowing what folks here think about this.

She said because many Latino families are concerned that the citizenship of their children is going to be challenged, they are more likely to have some of the documents readily available because they've had need for them in the past whereas some of the other families have never had need for this, to have the documents ready access to them.

Also she said that again having worked in Anova hospital, which is the big hospital system in Northern Virginia, her experience was that families apply for birth certificates very shortly after the birth of their child so that they have them on hand and again it's because they've been asked and they've been challenged. That's not the case for families at large and that was her explanation of why we saw this trend but again, this was another way of telling the story and talking about who actually experiences an impact and who

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does not.

I will close there and I think we have some time for questions but also for anyone who has some experiences and stories to tell of their own. I think this would be a good time to share some of that but first I want to ask, does anyone have any specific questions for Judith and Mike based on what they said or things that you'd like to know about what's going on in those states? Don't be shy [laughter].

MALE SPEAKER: And you've probably heard enough from me, but I look forward to, those were terrific presentations by the way and I look forward to reading Judith's full report and the methodology and I'm really interested in this piece about sort of telling the story and collecting information.

I'm curious, Mike, with the stories that you told, how you went about collecting that data whether it was just informally or were there any formal methods to do that because, as I mentioned earlier, and we do have a project with the National Health Law program to do some of that but we're always looking for new ways to—

MIKE FOGARTY: Yes. No these were anecdotal stories that were the response to a request I made to both our staff who deal with care management and who were getting phone calls from desperate people because of the loss of their access to care and also those county workers. So it was very informal and were stories that were just related by workers that knew those

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people.

BETH ABBOTT: I'm Beth Abbott [misspelled?] from Health Access. I would be interested in your comments about what Donna alluded to at the end, which is how do we talk about this when we're trying efforts to reconsider this in a legislative forum because many of the arguments on our side of the issue are sort of somewhat speculative, somewhat in the details that we uncover as to why people actually didn't pursue this.

It is easy for people on the other side to claim that the reason everybody left is, of course, they were not eligible and we've gotten the riff-raff off the rolls sort of response. I'd be interested in knowing what any of you think or people in the audience, for that matter about how we talk about this because I think framing this question is a really significant point going forward. Thank you.

JUDITH CASH: I'll start with that and I'm sure Mike will follow up but we had, Virginia legislators like Oklahomans who were dancing about the fact that we were capturing savings in our Medicaid program because the enrollment was dropping.

So we felt very strongly and, in fact, were successful in getting that message across with the combination of the data that we were able to provide that looked at how many children were falling off and that they were overwhelmingly not only U.S. citizens but Virginia's children who were falling off and by telling the stories.

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I think one of the things that is a rule at the Virginia Health Care Foundation, whenever we deliver a message, is that there are no stories without numbers and no numbers without stories. We always match the data and the personal story, the face of what's happening.

So if you have the opportunity to look at our full report, we actually have, and this actually goes to Chris to your question as well, we actually have some quotes, some vignettes, and many stories from eligibility workers who talk to us about the children they were not able to get covered like Mike had about the kids who were sick.

We had an eligibility worker tell us that they had a very sick baby who needed to be transferred to another hospital. The other hospital wouldn't take that baby until they got documentation that he was going to be covered by Medicaid. Those are the kinds of heart wrenching stories that the legislator from that county heard that story and took notice and followed up.

So I think it's really important when we talk about this that we really do have the data that show these are U.S. citizen kids. They are not getting enrolled in this huge number and here are some of them and they're you're constituents. They're your voters. They're in your backyard.

MIKE FOGARTY: I'd just add that my observation has been that there is a strong correlation between those elected

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officials who are enthusiastically supporting this law and those elected officials who love to bash government as being overfat, bureaucracy, expensive, wasting money, inefficient.

So to confront them and I've had some success in Oklahoma by, number one, making sure they understand that the savings, even though we've reduced the caseload, the savings are attributable in no way to the stated objective of the law.

I mean there may have been incidental savings and frankly my pitch on that is if you want to cover fewer people then let's just reduce the eligibility. Yes, let's just do that directly but then to confront them with the numbers, the GAO, the Office of Inspector General that anybody that's looked at this either state or federal and its contribution to wasteful administrative spending. That may be at least part of our hope.

RANDY BOYLE: Yes, I'm Randy Boyle [misspelled?] from the National Health Law Program. I was curious what your states are doing as far as helping people with the cost of obtaining the documentations.

And also and maybe when the California folks come up later, they could address the question of CMS is only requiring that you hold on to these documents for three years and, as we know, a lot of people can be on and off of aid throughout a lifetime and what are you doing as far as keeping those records so that five, ten years from now hopefully, someone doesn't have to provide that documentation again because it should

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truly be a once in a lifetime opportunity.

MIKE FOGARTY: Yes and I'll answer the one that I have the best answer for, that's the second one. Our operating theory is if we capture that in our data system and we had an indicator that says documentation done then it's done. Whether we can still go to a file cabinet and find the paper is really not relevant.

I think that will work. So that's at least our theory is if we've retained the record electronically and it has an indicator specific to that issue then that should suffice. I am intrigued and excited about the notion that Virginia is using state money to help overcome the expense. That is not something that we've been successful with in Oklahoma. We're having to wire, I just mentioned to you, I mean our sister agency at the very time this happened, the Health Department increased the fee for birth certificate from $10 to $15 because they have financial problems.

So we've got a disconnect frankly in Oklahoma on a system that will address that except for our enthusiastic efforts to avoid even having to ask for it because we really are investing in the data match. I mean I think that's where the answer is both by policy improvement so that more sources of data will be acceptable and also just by having the data retrieving resources to do that so that people aren't confronted with the need to do that.

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DONNA COHEN ROSS: I would just add and this goes to your question Randy as well that the idea is that if you do it once in your lifetime, that's supposed to be it but again with people who move around a lot, again if you move to another state, you're going to have that same problem that you might have had in the first place having to secure documentation from a state where is not the state that you live, so again these interstate systems so that if Mike has verified in Oklahoma that the person produced their documents.

When that person moves to Virginia or to California, you should be able to access some information to tell you that that person has done what they've been asked to do once and they don't have to be asked again but I think that is, someone asked me earlier why there wasn't sort of a federal, there weren't some areas of federal responsibility and initiative.

I think that's a very good question because anything that requires this interstate cooperation really does require that kind of leadership and we haven't seen it. It's not been helpful.

Are there other questions? I think we have time for one more. Manju, that's great.

MANJU KULKARNI: Hi. I have sort of a two-part question. I was wondering if any of the states have analyzed the cost in terms of the loss of federal Medicaid funds and also the increased cost of uninsured folks' utilization of ER visits. So

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for example, I mean I don't know to what extent your states are covering these individuals with state only funds but also in some ways, you must be paying for it because, as you both I think were able to show, there is an increased utilization of ER visits.

Then the second part of the question is about analyzing health outcomes. If there is any ongoing analysis of what actual impact like how someone specifically suffered because they were not able to show that and I know Mike, you have sort of started down that road but I was wondering if there's any real data analysis there.

MIKE FOGARTY: The short answer is no, not in a formal way but I'm anxious to do that. I mean I think that's obviously the next step. The other thing that's kind of indirectly related is one of our allies and this goes back to an earlier question about would we get this turned around, one of our allies are those health care providers out there that are now having to deal with that uncompensated care number but the number on loss of federal funds, I mean that's a sugar stick for anybody in the Medicaid business.

A sugar stick is for every dollar the state invests, we get this much return. That goes into our economy. It turns over four times. Those numbers work just exactly the same going out as they do coming in. So that number is easily retrievable.

JUDITH CASH: Yes and we have not actually done the math

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to identify that actual amount of lost federal Medicaid dollars but again, it's a number that we certainly can do. Unfortunately, that is still a hard nut to crack in Virginia.

It's still one of those things that even, and we talk about this all the time in terms of expanding Medicaid, even though for every dollar we spend, we get another dollar back, it's still hard for us to spend those state dollars on Medicaid and we still look for those Medicaid savings wherever we can. So that continues to be a real double-edged sword.

While we have, with our study, documented the impact on access to care, we don't have good data to document health outcome. In part, we get that anecdotally and we have a lot of it anecdotally as some of the stories that both of us have described but, unfortunately, we don't have good, real data around those health outcomes.

DONNA COHEN ROSS: Thank you. So that brings us to our close and I want to again thank Judith and Mike but all of you for the contributions in the question and answers and the experiences that you've also shared. I think the idea here is to tell this story in every possible way that it can be told and get as many people to care about it as possible including those people who you wouldn't expect to care. I think we're on the road to doing that.

I think we're now very fortunate that we're going to turn over the podium to all of you so that we can learn more

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about what's going on here in California and we're, I know, all looking forward eagerly to that. So thank you all very much [applause].

[END RECORDING]

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