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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship Documentation Interim
Final Rule, 71 Fed.Reg. 39214 (July 12, 2006)

The Progressive Leadership Alliance of Nevada is a multi-issue, statewide coalition of 40 member organizations addressing problems from racism to poverty to environmental justice. PLAN is committed to social and economic justice.

We are writing to comment on the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This provision of the DRA became effective on July 1 and requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity.

We are deeply concerned and disappointed that CMS has not acted to minimize the likelihood that U.S. citizens applying for or receiving Medicaid coverage will face delay, denial, or loss of Medicaid coverage.

We are concerned that the requirement that only originals and certified copies be accepted as satisfactory documentary evidence of citizenship adds to the burden of the new requirement on applicants, beneficiaries, and state Medicaid agencies. The requirement for originals and certified copies also calls into question the estimate that compliance with the requirement will only take an applicant or beneficiary ten minutes and state Medicaid agencies five minutes to satisfy the requirements of the regulations. Requiring that individuals obtain and submit originals and certified copies adds to the time compliance will take.

In addition to locating or obtaining their documents, applicants and beneficiaries will likely have to visit state offices to submit them. State agencies will have to meet with individuals, make copies of their documents, and maintain records.

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U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements. Under the DRA, the new citizenship documentation requirement applies to all individuals (other than Medicare beneficiaries and, in most states, SSI beneficiaries) who apply for Medicaid. The preamble to the rule states that applicants "should not be made eligible until they have presented the required evidence." 71 Fed. Reg. at 39216. The rule itself states that states "must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid." 42 CFR 435.407(j).

Under the DRA, documentation of citizenship is not a criterion of Medicaid eligibility. Once an applicant for Medicaid declares that he or she is a citizen and meets all eligibility requirements, eligibility should be granted. There is nothing in the DRA that requires a delay in providing coverage. Yet CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates.

This year, about 10 million U.S. citizens are expected to apply for Medicaid who are subject to this requirement. Most of these citizens are children, pregnant women and parents who will be subject to the new citizenship documentation requirement. The net effect of the prohibition on granting these individuals coverage until they provide documentation of their citizenship will be to delay Medicaid coverage for large numbers of eligible, low-income pregnant women, children and other vulnerable Americans. This is likely to delay their medical care, worsen their health problems and create financial losses for health care providers.

While the statutory logic of this policy is elusive, the real-world consequence is crystal clear. U.S. citizens who have applied for Medicaid, who meet all of the state's eligibility criteria, and who are trying to obtain the necessary documentation, will experience significant delays in Medicaid coverage. Some U.S. citizens who get discouraged or cannot get the documents they need within the time allowed by the state will never get coverage. Because there has been no outreach program to educate U.S. citizens about the new requirement, most applicants are likely to be unaware of it, and there are likely to be significant delays in assembling the necessary documents.

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We are particularly concerned about access to care by children, seniors, individuals in communities of color, particularly Native Americans, who in Nevada may not have access to proper documentation.

We urge CMS to revise 42 CFR 435.407(j) to state that applicants who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary documentation.

Children who are eligible for federal foster care payments should be exempt from the citizenship documentation requirement. The interim final rule applies the DRA citizenship documentation requirements to *all* U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. Among the children subject to the documentation requirements are roughly one million children in foster care, including those receiving federal foster care assistance under Title IV-E. State child welfare agencies must verify the citizenship status of these children in the process of determining their eligibility for Title IV-E payments.

It is our understanding that the Administration for Children and families (ACF) requires state child welfare agencies to follow the Department of Justice interim guidelines on verification of citizenship. Nonetheless, the preamble to the rule states that these children receiving Medicaid "must have in their Medicaid file a declaration of citizenship ... and documentary evidence of the citizenship ... claimed on the declaration." 71 Fed. Reg. at 39216

When Medicaid eligibility for children in foster care is delayed, foster parents may end up using emergency care as they will not have a Medicaid card. The child may not be able to receive essential non-emergency care — such as prescription drugs, psychological care, dental care or the purchase of medical supplies for conditions such as asthma — until the child's condition deteriorates to the point that it requires emergency care.

The DRA does not compel this result, which requires unnecessary duplication of state agency efforts and puts these children at risk of delayed Medicaid coverage. To the contrary, the DRA allows the Secretary to exempt individuals who are eligible for other programs that required documentation

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of citizenship. The IV-E program is precisely such a program, yet CMS, without explanation, elected not to exempt foster care children receiving such payments from the new documentation requirement, 71 Fed. Reg. at 39216. We urge CMS to revise 42 CFR 435.1008 to add children eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirement.

A state Medicaid agency's record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity. Among the children subject to the documentation requirements are infants born in U.S. hospitals. Newborns will not have birth records on file with state Vital Statistics agencies. The rule provides that in such circumstances, extracts of a hospital record created near the time of birth could be used as proof of citizenship, 42 CFR 435.407(c)(1), and if this "third level" of evidence was not available, a medical (clinic, doctor, or hospital) record created near the time of birth could be used, but only in the "rarest of circumstances," 42 CFR 435.407(d)(4).

Under current law, infants born to U.S. citizens receiving Medicaid at the time of birth are deemed to be eligible for Medicaid upon birth and to remain eligible for one year so long as the child remains a member of the woman's household and the woman remains eligible for Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule states that, in such circumstances, "citizenship and identity documentation for the child must be obtained at the next redetermination." 71 Fed. Reg. 39216. This makes no sense, since the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year bar on Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to be covered by Medicaid, an application must be filed and the citizenship documentation requirements would apply. 71 Fed. Reg. 39216. Again, this makes no sense, since the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen.

Because the rule would prevent states from granting coverage until documentation of citizenship is provided, hospitals and physicians treating newborns will be at risk for delay or denial of reimbursement for the treatment of newborns who are low-birthweight, have post-partum

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complications, or simply need well-baby care and who must, under the interim final rule, meet the documentation requirements.

The risk to the health of newborns from delays in coverage and the potential for increased uncompensated care for providers are completely unnecessary. The state Medicaid agency has already made the determination, by paying for the birth, that the child was born in a U.S. hospital. We strongly urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

CMS should adopt the approach taken by the Social Security Administration for U.S. citizens who lack documentation of their citizenship. There are U.S. citizens who will not be able to provide any of the documents listed in the interim final rule. Among these are victims of hurricanes and other natural disasters whose records have been destroyed, and homeless individuals whose records have been lost. The rule directs states to assist individuals with "incapacity of mind or body" to obtain evidence of citizenship, 42 CFR 435.407(g), but it does not address the situation in which a state is unable to locate the necessary documents for such an individual. Nor does the rule address the situation in which an individual does not have "incapacity of mind or body" but his or her documents have been lost or destroyed and, despite the best efforts of the individual or a representative, the documents cannot be obtained. As a result, under the rule if such individuals apply for Medicaid they can never qualify, and if such individuals are current beneficiaries, they will eventually lose their coverage.

As a last resort, the interim final rule allows the use of written affidavits to establish citizenship, but only when primary, secondary, or third-level evidence is unavailable, and "ONLY ... in rare circumstances," 42 CFR 435.407(d)(5). The requirements for these affidavits are rigorous, and it is likely that in a substantial number of cases they cannot be met, because two qualified individuals with personal knowledge of the events establishing the applicant's or beneficiary's claim to citizenship cannot be located or do not exist. In short, the rule simply does not recognize the reality that there are significant numbers of U.S. citizens without documents proving citizenship and without any idea that they need documents proving citizenship.

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We urge that the Secretary use this discretion to acknowledge that state Medicaid agencies have the capacity to recognize when a U.S. citizen without documents is in fact a U.S. citizen for purposes of Medicaid eligibility. The regulations for the SSI program allow people who cannot present any of the documents SSI allows as proof of citizenship to explain why they cannot provide the documents and to provide any information they do have. (20 CFR 416.1610) The Secretary should adopt a similar approach.

Specifically, 42 CFR 435.407 should be revised by adding a new subsection (k) to enable a state Medicaid agency, at its option, to certify that it has obtained satisfactory documentary evidence of citizenship or national status for purposes of FFP under section 435.1008 if (1) an applicant or current beneficiary, or a representative or the state on the individual's behalf, has been unable to obtain primary, secondary, third level, or fourth level evidence of citizenship during the reasonable opportunity period and (2) it is reasonable to conclude that the individual is in fact a U.S. citizen or national based on the information that has been presented.

CMS should not require applicants and beneficiaries to submit originals or certified copies. The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this as a requirement in the interim final regulations at 42 CFR 435.407(h)(1). This requirement adds greatly to the information collection burden of the regulations and calls into question the estimate that it will only take applicants and beneficiaries ten minutes and state agencies five minutes to comply.

Requiring original or certified copies adds to the burden of the new requirement for applicants, beneficiaries, and states and makes it more likely that health care providers will experience delays in reimbursement and increased uncompensated care.
Applicants and beneficiaries will have to make unnecessary visits to state offices with original and certified copies. While the regulations state that applicants and beneficiaries can submit documents by mail, it is not likely that many applicants and beneficiaries will be willing to mail in originals or certified copies of their birth certificates. Moreover, they will definitely not be willing or able to mail in proof of identity such as driver's licenses or school identification cards.

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Most states do not require a face-to-face interview for children and parents applying for or renewing their Medicaid coverage. Eliminating the face-to-face interview requirement was one of a number of steps states took to simplify their eligibility processes and make it easier for eligible children and parents to enroll in Medicaid.

Mail-in applications are also more efficient for state Medicaid agencies. Requiring originals and certified copies to document citizenship will make it harder for working families to enroll in Medicaid and increase the workload of Medicaid agencies. This unnecessary requirement that goes beyond the requirements Congress imposed in the DRA will also delay coverage while applicants wait for appointments at state Medicaid agencies. In some cases, having to visit a state office will discourage applicants from completing the application process. Children and families will go without coverage and remain uninsured and providers will not get reimbursed.

We urge CMS to revise the regulation by modifying the requirement at 42 CFR 435.407(h)(1) to make it clear that a state has the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when the state has no reason to believe that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.

Native Americans should be able to use a tribal enrollment card issued by a federally recognized tribe to meet the documentation requirement. While the interim final rule at 42 C.F.R. 437.407(e)(6) recognizes Native American tribal documents as proof of identity, the regulations does not permit tribal enrollment cards to be used as evidence of citizenship. We urge CMS to revise the regulation at 42 CFR 435.407(a) to specify that a tribal enrollment card issued by a federally-recognized tribe should be treated like a passport and deemed primary evidence of citizenship and identity.

The federal government recognizes over 560 tribes in 34 states. These federally recognized tribes have been recognized by the federal government through treaty negotiations, federal statutes, or a federal administrative recognition process. Tribal constitutions establishing membership requirements are approved by the federal government. Each federally recognized tribe is responsible for issuing tribal enrollment cards to its

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members for purposes of receiving services from the federal government as well as tribal resources and voting in tribal matters. With very few exceptions, tribes issue enrollment cards only to individuals who are born in the U.S. (and have a U.S. birth certificate) or who are born to parents who are members of the tribe and who are U.S. citizens. Tribal genealogy charts date back to original and historic tribal membership rolls.

In short, tribal enrollment cards are highly reliable evidence of U.S. citizenship. In the event a federally recognized tribe located in a state that borders Canada or Mexico issues tribal enrollment cards to non-U.S. citizens, the Secretary could require additional documentation of U.S. citizenship and tribal enrollment cards would qualify as evidence of identity but not citizenship.

The Progressive Leadership Alliance of Nevada appreciates this opportunity to comment on the proposals of DRA and hope you will consider the recommended changes that we have made.

Thank you, Jan Gilbert

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New York State Office of Children & Family Services

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Commissioner

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August 1, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, Maryland 21244-8017

Re: Interim Final Rule Federal Register July 12, 2006, 71 Fed. Reg. 39214-39229

Dear Sir/Madame:

The New York State Office of Children and Family Services (OCFS) is responsible for the supervision of the foster care and child welfare programs in the State of New York. I write to advise you of difficulties in meeting the new standards for documenting the citizenship and identity of some children in foster care as a condition of their receipt of Medicaid. This letter will also suggest recommendations to address these concerns.

At the outset we note that children are removed from their homes only when there are no relatives or alternative placement available that can provide for the safety and well-being of them. Upon removal, the first priority is to minimize the trauma to the child(ren) and family, and access a secure and safe placement. This may also necessitate immediate access to medical services for the child. The removal of a child, particularly in abuse and neglect situations, is the most traumatic and chaotic time for the family. The families from whom children are removed often have transient lifestyles and living arrangements due to the parent's instability of income, abuse of drugs or alcohol, violence, criminal behavior or serious mental illness. Parents may not even be present or available at the time of removal In child protective services cases, children are being removed contrary to the wishes of the parent, who often is totally uncooperative with the agency removing the child(ren). At this time of crisis, access to any documentation of citizenship or identity for children, and more importantly access to original documentation, which is required by the DRA standards, is problematic. These circumstances are in clear contrast to where a parent affirmatively approaches the government for assistance.

During the child's first thirty days of foster care, we require a comprehensive assessment of the child's health. Generally children in foster care have complex physical, emotional and developmental health needs. Medicaid coverage is required in order to fund this assessment and address the child's health needs.

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Many children in foster care are under age five and not attending school or may not be attending schools that have school identification cards that include photos. For infants or other very young children who have been abandoned, or a child who does not know precisely where they were born, there may be no capacity to verify citizenship or identity. However, there may be strong circumstantial evidence that the child is a citizen by virtue of birth in the United States. For example, a child abandoned at a local fire or police station located far from any international land boarder shortly after birth can be presumed to have been born near the place of abandonment and hence a United States citizen.

Our first recommendation is that the list of acceptable documentation of identity be amended to permit a court order removing a specified child from the child's home as an acceptable document establishing the child's identity. Additional evidence should not be required to establish the identity of the child. In this manner, a birth certificate and a court order of removal fully satisfy the citizenship and identity documentation requirements. Also, we suggest adding to the list of documentation that can establish identity school or pre-school records that do not have photo identifications but identify the child by name.

Our second recommendation is that for children who are removed from families that are in receipt of Medicaid at the time of the removal, to allow Medicaid eligibility to continue for these removed children. In addition, that CMS accept any documentation that establishes the citizenship and identity of the children that is contained in other records required to establish eligibility for other federally funded programs that the family was in receipt of at the time of removal.

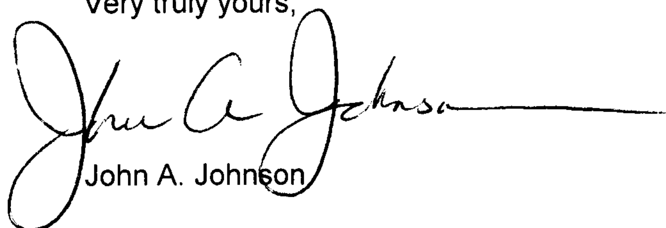
Our third recommendation is that children, regardless of documentation of citizenship should be eligible for emergency room services under the same circumstances that aliens may receive such services. Again, this is vital given the high prevalence for the need for such care in regard to abused children.

Our fourth recommendation refers to children under the age of five and that a presumption of citizenship be established unless there is strong evidence to believe otherwise and that the "period of reasonable opportunity" to gather necessary documentation be increased to six months. Medicaid should continue during this six-month period.

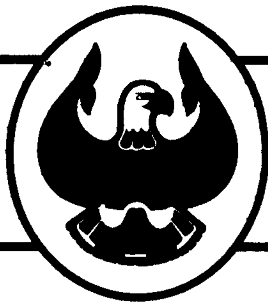
We also note that the Final Rule contains two citation errors. The reference to 42 U.S.C. 1641 should be 8 U.S.C. 1641 and the reference to 42 C.F.R. Part 74 should be part 92. The September 8, 2003 Final Rule (68 Fed. Reg. 52843) made the administration of certain entitlement programs subject to the 45 CFR Part 92 Common Rule, rather than to 45 CFR Part 74.

OCFS appreciates this opportunity to comment and invites CMS to direct all inquiries on this matter to Nancy Martinez, Director of Strategic Planning and Policy Development at 518-473-1776.

Very truly yours,



John A. Johnson



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LUMMI INDIAN BUSINESS COUNCIL

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DEPARTMENT____EXT.__________

July 26, 2006

Center for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 221244-1850

To whom it may concern:

Subject: Comments to Interim Final Rule: Medicaid Program: Citizenship Documentation Requirements, 71 Federal Register 39214 (July 12, 2006); File Code: CMS-2257-IFC

Thank you for the opportunity to provide comments to the interim final rule, published in the Federal Register on July 12, 2006, at Vol. 71, No. 133, amending Medicaid regulations to implement the new documentation requirements of the Deficit Reduction Act (DRA) requiring persons currently eligible for or applying for Medicaid to provide proof of U.S. citizenship and identity.

I am disappointed that the interim regulations do not recognize a Tribal enrollment card or Certificate of Degree of Indian Blood (CDIB) as legitimate documents of proof of U.S. citizenship. The June 9, 2006 State Medicaid Directors (SMD) guidance indicates that the Centers for Medicare and Medicaid Services (CMS) consulted with the CMS Tribal Technical Advisory Group (CMS TTAG) in the development of this guidance. While Native American tribal documents and CDIBs are recognized as legitimate documents for identification purposes, the CMS SMD guidance did not include Tribal enrollment cards or CDIBs as legitimate documents of proof of citizenship. Prior to the publication of the interim regulations, the National Indian Health Board (NIHB), the CMS TTAG, and the National Congress of American Indians (NCAI) requested the Secretary of the Department of Health and Human Services to exercise his discretion under the DRA to recognize Tribal enrollment cards or CDIBs as legitimate documents of proof of citizenship in issuing the regulations. However, tribal concerns expressed by the national Indian organizations and the CMS TTAG were not incorporated into the interim regulations.

As Sally Smith, Chairman of the NIHB, wrote in a letter to Congressional leaders on this issue, Tribal governments find it "rather ironic that Native Americans, in the true sense of the word, must prove their U.S. citizenship through documentation other than through

their Tribal documentation. This same Tribal documentation is currently recognized by Federal agencies to confer Federal benefits by virtue of American Indian and Alaska Native (AI/AN) Tribal governments' unique and special relationship with the U.S. dating back to, and in some circumstances prior to, the U.S. Constitution."

There are 563 Federally-recognized Tribes in the U.S. whose Tribal constitutions include provisions establishing membership in the Tribe. The Tribal constitutions, including membership provisions, are approved by the Department of Interior. Documentation of eligibility for membership is often obtained through birth certificates but also through genealogy charts dating back to original Tribal membership rolls, established by Treaty or pursuant to Federal statutes. The Tribal membership rolls officially confer unique Tribal status to receive land held in trust by the Federal government, land settlements, and other benefits from the Federal government. Based on heroic efforts of Indians serving in the military during World War I, the Congress in 1924 granted U.S. citizenship to members of Federally Recognized Tribes. To this day, Tribal genealogy charts establish direct descendency from these Tribal members. With very few exceptions, Federally-recognized Tribes issue Tribal enrollment cards or CDIBs to members and descendants of Federally Recognized tribes who are born in the U.S. or to persons descended from someone who was born in the United States. Thus, Tribal enrollment cards or CDIBs should serve as satisfactory documentation of evidence of U.S. citizenship as required by the DRA.

In developing the interim regulations, the CMS might have been concerned that some Tribes issue enrollment cards to non-citizens and determined that Tribal enrollment cards or CDIBs are not reliable documentation of U.S. citizenship for Medicaid eligibility purposes under the DRA. However, members of Indian Tribes, regardless of citizenship status, are already eligible for Federal public benefits, including Medicaid, under exceptions to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Title IV of the PRWORA provides that with certain exceptions only United States citizens, United States non-citizen nationals, and "qualified aliens" are eligible for federal, state, and local public benefits. Pursuant to Federal regulations at 62 Federal Register 61344 (November 17, 1997) non-citizen Native Americans born outside of the United States who either (1) were born in Canada and are at least 50% American Indian blood, or (2) who are members of a Federally recognized tribe are eligible for Medicaid and other Federal public benefits, *regardless of their immigration status.* The documentation required for purposes of the PRWORA is a membership card or other tribal document demonstrating membership in a federally-recognized Indian tribe under section 4(e) of the Indian Self-Determination and Education Assistance Act. Thus, tribal membership cards issued to members of Federally-recognized tribes, including non-U.S. citizen tribal members, are satisfactory proof of documentation for Medicaid eligibility purposes under the PRWORA. The documentation requirements under the DRA should be the same.

The interim regulations, at 42 C.F.R. 437.407(e)(6) and (e)(8)(vi), recognize Native American tribal documents as proof of identity. Section 437.407(e)(9) recognizes CDIBs as evidence of identity because they include identifying information such as the person's

name, tribal affiliation, and blood quantum. Since the CMS already recognizes Native American tribal documents or CDIBs as satisfactory documentation of identity, there is sufficient basis for CMS to recognize Tribal enrollment cards or CDIBs as satisfactory documentation of primary evidence of both U.S. citizenship AND identity. The term Native American tribal document is found in the Department of Homeland Security, Form I-9, where Native American tribal documents suffice for identity and employment eligibility purposes. The interim regulations do not define the term 'Native American tribal document" but certainly, Tribal enrollment cards or CDIBs fall within the scope of a "Native American tribal document." Thus, I recommend that section 435.407 (a) of the regulations be amended to include Tribal enrollment cards or CDIBs as Tier 1 documents.

In the alternative, if CMS will not amend the regulations at 435.407(a) to include Tribal enrollment cards or CDIBs as primary evidence of citizenship and identity, I recommend that the CMS recognize Tribal enrollment cards or CDIBs as legitimate documents of citizenship as a Tier 2 document, secondary evidence of citizenship. The regulations only allow identification cards issued by the Department of Homeland Security to the Texas Band of Kickapoos as secondary evidence of citizenship and census records for the Seneca and Navajo Tribes as fourth-level evidence of citizenship. However, in light of the exception found in the PRWORA, the regulations at 435.407(b) should be amended to include Tribal enrollment cards for all 563 Federally-recognized Tribes as secondary evidence of U.S. citizenship.

The Senate Finance Committee in unanimously reporting out S. 3524 included an amendment to section 1903(x)(3)(B) of the Social Security Act [42 U.S.C. 1396(x)(3)(B)] to allow a "document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe" to serve as satisfactory documentation of U.S. citizenship. In addition, the amendments provide further that " [w}ith respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection." S. 3524 also provides for a transition period that " until regulations are issued by the Secretary, tribal documentation shall be deemed satisfactory evidence of citizenship or nationality for purposes of satisfying the requirements of section 1903 of the Act." Although S. 3524 has not been enacted, amending the interim regulations to include tribal enrollment cards or CDIBs as satisfactory documentation of proof of citizenship would be consistent with this recent Congressional action to clarify the DRA.

I would urge CMS to amend the interim regulations to address tribal concerns by recognizing Tribal enrollment cards as Tier 1 documents, or in the alternative, Tier 2 documents. As explained above, with very few exceptions, Tribes issue enrollment cards or CDIBs to their members after a thorough documentation process that verifies the

individual is a U.S. citizen or a descendant from a U.S. citizen. To the extent, the Secretary has concerns that some Tribes might issue enrollment cards or CDIBs to non-U.S. citizens, the exceptions under the PRWORA should address these concerns.

If tribal enrollment cards or CDIBs are not recognized as proof of U.S. citizenship, either as a Tier 1 or Tier 2 document, AI/AN Medicaid beneficiaries might not be able to produce a birth certificate or other satisfactory documentation of place of birth. Many traditional AI/ANs were not born in a hospital and there is no record of their birth except through tribal genealogy records. By not recognizing Tribal enrollment cards as satisfactory documentation of U.S. citizenship, the CMS is creating a barrier to AI/ANs access to Medicaid benefits. As you know, the Indian health care programs, operated by the IHS, tribes/tribal organizations, and urban Indian organizations, as well as public and private hospitals, that provide services to AI/ANs are dependent on Medicaid reimbursements to address extreme health care disparities of the AI/AN population compared to the U.S. population. Recognizing Tribal enrollment cards or CDIBs as sufficient documentation of U.S. citizenship will benefit not only Indian health care programs but all of the health care providers located near Indian country that provide services to AI/AN Medicaid beneficiaries.

Thank you for your thoughtful consideration of my comments.

Sincerely,

Evelyn Jefferson, LIBC Chairwoman
Lummi Indian Nation

Cc: Senator Maria Cantwell, WA. St.
Senator Patty Murray, WA. St.
Representative Rick Larsen, WA. St.
NIHB

24-1

August 15, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE Recognition of Tribal Enrollment Cards as Proof of U.S. Citizenship for Medicaid purposes

Dear Centers for Medicare & Medicaid Services Official:

In response to the interim final rule published in the Federal Register on July 12, 2006, at Vol. 71, No. 133, and amending Medicaid regulations to implement the new documentation requirements of the Deficit Reduction Act requiring persons currently eligible for or applying for Medicaid to provide proof of U.S. citizenship and identity, these regulations must be adjusted to clearly recognize Tribal enrollment cards or Certificate of Degree of Indian Blood (CDIB) cards as legitimate documents of proof of U.S. citizenship. This same Tribal documentation is currently recognized by Federal agencies to confer Federal benefits by virtue of American Indian and Alaska Native Tribal governments' unique and special relationship with the U.S. dating back to, and in some circumstances prior to, the U.S. Constitution. I echo the sentiments of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group, the National Indian Health Board and the National Congress of American Indians on this issue when I say that CMS must clearly recognize tribal enrollment cards as proof of U.S. Citizenship for Medicaid purposes.

It is important to note that the Senate Finance Committee in reporting out S. 3524 included an amendment to section 1903(x)(3)(B) of the Social Security Act (42 U.S.C. 1396(x)(3)(B) to allow a "document issued by a federally-recognized Indian tribe evidencing membership or enrollment in, or affiliation with, such tribe" to serve as satisfactory documentation of U.S. citizenship. In addition the amendments provided further that "[w}ith respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, the Secretary shall, after consulting with such tribes, issue regulations authorizing the presentation of such other forms of documentation (including tribal documentation, if appropriate) that the Secretary determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subsection." S. 3524 also provides for a transition period that, until regulations are issued by the Secretary, tribal documentation shall be deemed satisfactory evidence of citizenship or nationality for purposes of satisfying the requirements of section 1903 of the Act.

The Tribal constitutions, including membership provisions, are approved by the Federal government. Pursuant to the Snyder Act, 25 U.S.C. 13, the Federal government's scope of authority to provide Federal benefits extends to "Indians throughout the United States." Thus, with very few exceptions, Federally-recognized Tribes issue Tribal enrollment cards to members and descendants of Federally

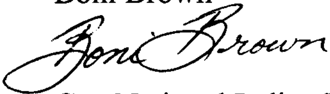
Recognized tribes who are born in the U.S. or to persons descended from someone who was born in the United States, consistent with the definition of U.S. citizenship, see 8 U.S.C. 1401.

Since the CMS already recognizes Native American tribal documents as satisfactory documentation of identity, there is sufficient basis for CMS to clearly recognize Tribal enrollment cards as satisfactory documentation of primary evidence of both U.S. citizenship AND identity. Thus, I recommend that section 435.407 (a) be amended to include Tribal enrollment cards as Tier 1 documents.

If tribal enrollment cards are not recognized as proof of U.S. citizenship, either as a Tier 1 or Tier 2 document, AI/AN Medicaid beneficiaries might not be able to produce a birth certificate or other satisfactory documentation of place of birth. Many traditional AI/ANs were not born in a hospital and there is no record of their birth except through tribal genealogy records. By not recognizing Tribal enrollment cards as satisfactory documentation of U.S. citizenship, the CMS is creating a barrier to AI/AN participation in the Medicaid program.

Sincerely,

Boni Brown



Cc: National Indian Health Board

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AFSCME®

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August 1, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

RE: CMS 2257-IFC

Dear Sir or Madam:

I am submitting these comments on behalf of the 1.4 million members of the American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO. AFSCME represents thousands of Medicaid eligibility determination workers and more than 100,000 health care workers. We have grave concerns about some of the provisions in the interim final rule, published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA).

We are deeply concerned and disappointed that CMS has not acted to minimize the likelihood that U.S. citizens applying for or receiving Medicaid coverage will face delay, denial, or loss of Medicaid coverage. AFSCME Medicaid eligibility workers are on the front lines implementing these provisions. The regulations add burdensome requirements to workloads that already are unmanageable. Our comments below highlight areas that CMS should modify in the final rule.

CMS should not require applicants and beneficiaries to submit originals or certified copies.

We are concerned that the requirement that only originals and certified copies be accepted as satisfactory documentary evidence of citizenship adds to the burden of the new requirement on applicants, beneficiaries, and state Medicaid agencies. The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this as a requirement in the interim final regulations at 42 CFR 435.407(h)(1). This requirement adds greatly to the information collection burden of state agencies.

The regulations suggest that these requirements will only take an applicant or beneficiary ten minutes and state Medicaid agencies five minutes to satisfy the requirements of the regulations. These time estimates are unreasonable and not based on the real circumstances applicants and recipients face. Many do not have the documents readily available. Many do not have passports or original birth certificates and will need help from eligibility workers in figuring out the process to obtain the necessary documentation. Applicants and beneficiaries will have to make unnecessary visits to state offices with original and certified copies. While the regulations state that applicants and beneficiaries can submit documents by mail, it is not likely that many applicants and beneficiaries will be willing to mail in originals or certified copies of their birth certificates. Moreover, they will definitely not be willing or able to mail in proof of identity such as driver's licenses or school identification cards. Applicants and beneficiaries will have to visit state offices more than once for assistance and in order to submit the documentation; and eligibility workers will have to meet with individuals, make copies of their original documents, and maintain records. Thus the time estimates, both for the eligibility workers and the applicants/recipients, are unrealistic. These requirements will necessarily increase state administrative costs. Delays in getting the documentation also will delay the certification period because of other provisions in the proposed rules.

States that adopted the practice of presumptive eligibility to streamline their enrollment process have uniformly credited it for helping get applicants necessary services in a timely manner. Any errors in enrollment are caught within the first few months, when staff have more time to ascertain accuracy of information. But the hallmark of this practice is that it does not promote enrollment delays and helps provide the seamless services that are the goal of the Medicaid program. States should be able to extend this practice to the implementation of these new regulations.

Most states do not require a face-to-face interview for children and parents applying for or renewing their Medicaid coverage. Eliminating the face-to-face interview requirement was one of a number of steps states took to simplify their eligibility processes and make it easier for eligible children and parents to enroll in Medicaid. Mail-in applications are also more efficient for state Medicaid agencies. Requiring originals and certified copies to document citizenship will make it harder for working families to enroll in Medicaid and increase the workload of Medicaid agencies. This unnecessary requirement that goes beyond the requirements Congress imposed in the DRA will also delay coverage while applicants wait for appointments at state Medicaid agencies. And state agencies will be overwhelmed with requests for assistance from applicants and recipients, adding to the program's administrative costs.

In fact, it is likely that state agencies may find it necessary to hire more employees to deal with the increased administrative burden and the new level of outreach/education necessitated by these regulations. In effect, the goal of the DRA to reduce Medicaid spending may actually be undermined by implementation of these interim final regulations.

Requiring originals or certified copies will make it difficult for children in foster care to qualify for Medicaid. Child welfare agencies will likely have copies of birth certificates for many of these children that were obtained as part of the process for determining whether the children are eligible for federal foster care payments. It would be simple for the child welfare agencies to make copies available to the Medicaid agencies, but this is precluded by the requirement for originals or certified copies.

Recommendation:

We urge CMS to revise the regulation by modifying the requirement at 42 CFR 435.407(h)(1) to make it clear that a state has the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when the state has no reason to believe that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.

<u>U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements.</u>

Under the DRA, the new citizenship documentation requirement applies to all individuals (other than Medicare beneficiaries and, in most states, SSI beneficiaries) who apply for Medicaid. The preamble to the rule states that applicants "should not be made eligible until they have presented the required evidence." The rule itself states that states "must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid."

Under the DRA, documentation of citizenship is not a criterion of Medicaid eligibility. Once an applicant for Medicaid declares that he or she is a citizen and meets all eligibility requirements, eligibility should be granted. There is nothing in the DRA that requires a delay in providing coverage. Yet CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates.

This year, about 12 million U.S. citizens are expected to apply for Medicaid. Most of these citizens are children, pregnant women and parents who will be subject to the new citizenship documentation requirement. The effect of the prohibition on granting these individuals coverage until they provide documentation of their citizenship will be to delay Medicaid coverage for large numbers of eligible, low-income pregnant women, children and other vulnerable Americans. This is likely to delay their medical care, worsen their health problems and create financial losses for health care providers.

The result will be that U.S. citizens who have applied for Medicaid, who meet all of the state's eligibility criteria, and who are trying to obtain the necessary documentation, will experience significant delays in Medicaid coverage. Some U.S. citizens who get discouraged or cannot get the documents they need within the time allowed by the state will never get coverage. Because there has been no outreach program to educate U.S. citizens about the new requirement, most applicants are likely to be unaware of it, and there are likely to be significant delays in assembling the necessary documents.

Health care providers will not receive Medicaid payment for services rendered until the documentation has been assembled and presented to the state Medicaid agency. In some cases they may never receive reimbursement. We are also concerned that families will forego preventive care and children will end up in an emergency room when a crisis arises.

Recommendation:

We urge CMS to revise 42 CFR 435.407(j) to state that applicants who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary documentation.

Children who are eligible for federal foster care payments should be exempt from the citizenship documentation requirement.

The interim final rule applies the DRA citizenship documentation requirements to all U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. Among the children subject to the documentation requirements are roughly one million children in foster care, including those receiving federal foster care assistance under Title IV-E. State child welfare agencies must verify the citizenship status of these children in the process of determining their eligibility for Title IV-E payments.

Currently, the Administration for Children and Families (ACF) requires state child welfare agencies to follow the Department of Justice interim guidelines on verification of citizenship. Nonetheless, the preamble to the rule states that these Title IV-E children receiving Medicaid "must have in their Medicaid file a declaration of citizenship ... and documentary evidence of the citizenship ... claimed on the declaration." We recommend that foster care children be treated as current beneficiaries rather than applicants,

When Medicaid eligibility for children in foster care is delayed, foster parents may end up using emergency care because they will not have a Medicaid card. The child may not be able to receive essential non-emergency care, such as prescription drugs, psychological care, dental care or the purchase of medical supplies for conditions such as asthma, until the child's condition deteriorates to the point that it requires emergency care.

This requirement is unnecessary duplication of state agency efforts and puts these children at risk of delayed Medicaid coverage. The DRA allows the Secretary to exempt individuals who are eligible for other programs that require documentation of citizenship. The IV-E program is precisely such a program, yet CMS elected not to exempt foster care children receiving such payments from the new documentation requirement.

Recommendation:

We urge CMS to revise 42 CFR 435.1005 to add children eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirement.

<u>A state Medicaid agency's record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity.</u>

Among the children subject to the documentation requirements are infants born in U.S. hospitals. Newborns will not have birth records on file with state Vital Statistics agencies. The rule provides that in such circumstances, extracts of a hospital record created near the time of birth could be used as proof of citizenship, and if this "third level" of evidence was not available, a medical (clinic, doctor, or hospital) record created near the time of birth could be used, but only in the "rarest of circumstances."

Under current law, infants born to U.S. citizens receiving Medicaid at the time of birth are deemed to be eligible for Medicaid upon birth and to remain eligible for one year as long as the child remains a member of the woman's household and the woman remains eligible for Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule states that, in such circumstances, "citizenship and identity documentation for the child must be obtained at the next redetermination." This makes no sense, since the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year bar on Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to be covered by Medicaid, an application must be filed and the citizenship documentation requirements would apply. Again, this makes no sense, since the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen.

The rule would prevent states from granting coverage until documentation of citizenship is provided, so as a result hospitals and physicians treating newborns will be at risk for delay or denial of reimbursement for the treatment of low-birthweight newborns, post-partum complications, or well-baby care.

The risk to the health of newborns from delays in coverage and the potential for increased uncompensated care for providers are completely unnecessary. The state Medicaid agency has already made the determination, by paying for the birth, that the child was born in a U.S. hospital.

Recommendation:

We strongly urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

CMS should adopt the approach taken by the Social Security Administration for U.S. citizens who lack documentation of their citizenship.

Some U.S. citizens will not be able to provide any of the documents listed in the interim final rule. Among these are victims of hurricanes and other natural disasters whose records have been destroyed, and homeless individuals whose records have been lost. Individuals born outside of hospitals may not have birth certificates, particularly in rural areas. The rule directs states to assist individuals with "incapacity of mind or body" to obtain evidence of citizenship, but it does not address the situation in which a state is unable to locate the necessary documents for such an individual. . Nor does the rule address the situation in which an individual does not have "incapacity of mind or body" but his or her documents have been lost or destroyed and, despite best efforts, the documents cannot be obtained. Under the rule, if such individuals apply for Medicaid they can never qualify, and if such individuals are current beneficiaries, they will eventually lose their coverage.

As a last resort, the interim final rule allows the use of written affidavits to establish citizenship, but only when primary, secondary, or third-level evidence is unavailable, and "only ... in rare circumstances." The requirements for these affidavits are rigorous, and it is likely that in a substantial number of cases they cannot be met, because two qualified individuals with personal knowledge of the events establishing the applicant's or beneficiary's claim to citizenship cannot be located or do not exist. In short, the rule simply does not recognize the reality that there are significant numbers of U.S. citizens without documents proving citizenship and without any idea that they need documents proving citizenship.

The DRA gives the Secretary discretion to expand on the list of documents included in the DRA that are considered to be "proof" of citizenship and a "reliable means" of identification. We urge that the Secretary use this discretion to acknowledge that state Medicaid agencies have the capacity to recognize when a U.S. citizen without documents is in fact a U.S. citizen for purposes of Medicaid eligibility.

The regulations for the SSI program allow people who cannot present any of the documents SSI allows as proof of citizenship to explain why they cannot provide the documents and to provide any information they do have. (20 CFR 416.1610) The Secretary should adopt a similar approach.

Recommendation:

Specifically, 42 CFR 435.407 should be revised by adding a new subsection (k) to enable a state Medicaid agency, at its option, to certify that it has obtained satisfactory documentary evidence of citizenship or national status for purposes of FFP under section 435.1008 if (1) an applicant or current beneficiary, or a representative or the state on the individual's behalf, has been unable to obtain primary, secondary, third level, or fourth level evidence of citizenship during the reasonable opportunity period and (2) it is reasonable to conclude that the individual is in fact a U.S. citizen or national based on the information that has been presented. This approach would ensure that U.S. citizens can continue to receive the health care services they need.

<u>Native Americans should be able to use a tribal enrollment card issued by a federally-recognized tribe to meet the documentation requirement.</u>

While Native American tribal documents can be used as proof of identity, the regulations do not permit tribal enrollment cards to be used as evidence of citizenship. With very few exceptions, tribes issue enrollment cards only to individuals who are born in the U.S. (and have a U.S. birth certificate) or who are born to parents who are members of the tribe and who are U.S. citizens. Thus, tribal enrollment cards are highly reliable evidence of U.S. citizenship. An exception should be made in the case of a federally-recognized tribe located in a state that borders on Canada or Mexico that the Secretary finds issues tribal enrollment cards to non-citizens; in such cases, tribal enrollment cards should qualify as evidence of identity but not citizenship.

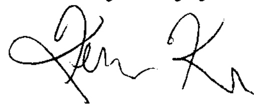
If the list of documents that can be used by Native Americans to prove citizenship and identity is not expanded, it is likely that many Native Americans will be unable to meet the new requirement and will go without Medicaid coverage.

Recommendation:

We urge CMS to revise the regulation at 42 CFR 435.407(a) to specify that a tribal enrollment card issued by a federally-recognized tribe should be treated like a passport and deemed primary evidence of citizenship and identity.

In summary, we hope that CMS incorporates the changes we have recommended to ensure that U.S. citizens entitled to Medicaid receive it, health care providers receive compensation for the care they provide, and administrative costs do not increase dramatically. Incorporating our recommendations would mitigate the impact on U.S. citizen applicants and recipients required to document their citizenship and identity, and limit the increase in administrative costs to implement the provisions of the DRA.

Very truly yours,



Kerry Korpi
Director
Department of Research and
Collective Bargaining Services

KK:CP:gam

26

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August 7, 2006

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Medicaid Citizenship Documentation
Interim Final Rule, 71 FR 39214
(July 12, 2006)

Dear Secretary Leavitt:

Legal Services of Southern Piedmont is a public interest law firm representing low income residents of North Carolina in civil matters, including access to health care. Many of our clients are Medicaid applicants and recipients. We are writing to comment on the Interim Final Rule on Citizenship Documentation, which was published in the Federal Register on July 12, and implements § 6036 of the Deficit Reduction Act of 2005 (DRA).

We have already identified several current clients who are Medicaid applicants or recipients, who will have great difficulty complying with the requirements of this interim rule, and for whom essential health coverage may be lost if changes to the rule are not made. No birth certificates exist for persons born in N.C. before 1913 and such persons are very unlikely to know anyone still alive who was present at their birth. Many Medicaid recipients in N.C. do not have birth certificates because they were not born in hospitals, either because of racial discrimination or indigence or distance to a hospital.

We have been communicating regularly with the N.C. Medicaid agency about this rule, and the state agency shares many of our concerns. For example, there is currently in N.C. no on-line match capability with the N.C. Division of Vital Records. It will be at least a year before this changes. The only outreach about this requirement to Medicaid recipients by the N.C. agency thus far was a request to counties to place a letter sized "poster" in Social Services waiting rooms. The expense of this rule in both caseworker time and in paying for birth certificates will be extremely burdensome to 100 different N.C. counties, who must pay 50% of Medicaid

administrative costs. The poorest of these counties are already financially overwhelmed with Medicaid administrative costs.

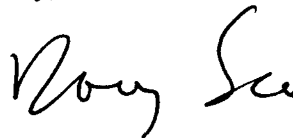
The N.C. Medicaid agency has attempted to reduce county burdens by processing many Medicaid applications and most redeterminations by mail. However, the requirements in the rule for original documents and for wading through a complex hierarchy of documents will likely make it very difficult to continue to process these determinations by mail and telephone.

We are told by N.C. officials that because of the computer linkage between Medicaid and other programs, N.C. may deny or terminate both TANF and State-County Special Assistance (an SSI state supplement that pays for assisted living care) as well as Medicaid to persons who cannot meet the requirements of this rule. The same linkage problem exists for children in IV-E foster care.

The exemption for SSI and Medicare recipients in the Interim Rule is very welcome news. However, N.C. provides Medicaid to a large number of disabled adults who do not yet receive SSI or Medicare for two reasons. First, there is a 29 month waiting period for Medicare after the disability onset date for Social Security recipients, many of whom are over the SSI income limit but under the Medicaid income limit. Second, the state Medicaid agency often approves disability years before the Social Security Administration does so. Many of these Medicaid recipients have both mental and physical disabilities and have no income while awaiting SSA approval of their disability claims. They are likely to face significant difficulties in obtaining the evidence this rule requires.

Thank you for the time you have taken to consider these comments. I hope that you will find them helpful as you consider the best ways to improve the proposed Rule in ways that will reduce the burdens on Medicaid applicant/recipients and on state and local governments.

Sincerely,



Douglas Sea
Attorney at Law

American Academy of Pediatrics

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August 4, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship Documentation Interim Final Rule
71 Fed.Reg. 39214 (July 12, 2006)

Dear Sir/Madam:

On behalf of the 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists of the American Academy of Pediatrics (AAP), I write today to comment on the Interim Final Rule addressing Citizenship Documentation Requirements published on July 12, 2006 (the "rule") to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This section of the DRA requires Medicaid enrollees to document their citizenship and identity effective July 1, 2006. At least 28 million low-income children will be affected by this new requirement. While appreciative of the significant evolution from CMS's past guidance to states for those children who may qualify as disabled, AAP remains deeply concerned that the rule will hurt children who qualify for Medicaid but find it difficult to prove. As set forth below, AAP views these aspects of the rule as problematic.

Newborns

The interim final rule applies the DRA citizenship documentation requirements to all U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. Among the children subject to the documentation requirements are infants born in U.S. hospitals. These infants may not have birth records on file with state Vital Statistics agencies due to application or processing delays. The rule provides that in such circumstances, extracts of a hospital record created near the time of birth could be used as proof of citizenship, 42 CFR 435.407(c)(1), and if this "third level" of evidence is not available, a medical (clinic, doctor, or hospital) record created near the time of birth could be used, but only in the "rarest of circumstances," 42 CFR 435.407(d)(4). A health insurance record, including a record of Medicaid payment for the birth in a U.S. hospital, would not satisfy the interim final rule unless it was created at least 5 years before the initial application date, effectively nullifying the use of this evidence for infants born on or after July 1, 2005, the oldest of whom will be turning age one as of July 1, 2006. 42 CFR 435.407(c)(2).

Under current law, infants born to U.S. citizens receiving Medicaid at the time of birth are deemed to be eligible for Medicaid upon birth and to remain eligible for one year so long as the child remains a member of the woman's household and the woman remains eligible for

Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule states that, in such circumstances, "citizenship and identity documentation for the child must be obtained at the next redetermination," (71 Fed. Reg. 39216), even though the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is, by definition, a citizen. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant (subject to the 5-year bar on Medicaid coverage), or an undocumented immigrant, the preamble states that in order for the newborn to be covered by Medicaid, an application must be filed and the citizenship documentation requirements would apply. 71 Fed. Reg. 39216. Again, the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen.

As discussed above, the preamble to the interim final rule takes the position that an applicant is not eligible for Medicaid until the documentation requirements have been satisfied. Newborns who must apply for Medicaid are subject to this same non-payment policy. Pediatricians treating newborns in these circumstances will be at risk for delay or denial of payment for the treatment of newborns who are low-birthweight, have post-partum complications, or simply need well-baby care and who must, under the interim final rule, meet the documentation requirements. This risk is completely unnecessary because the state Medicaid agency has already made the determination, by paying for the birth that the child qualifies for Medicaid benefits. We strongly urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

Applicants and Reasonable Opportunity

Under the DRA, the new citizenship documentation requirement applies to children who apply for Medicaid on or after July 1, 2006. The new 42 CFR 435.407(j) requires states to give an applicant "a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid." No time period is specified, but the rule does state that the "reasonable opportunity" should be "consistent with the time allowed to submit documentation to establish other facets of eligibility for which documentation is requested." 71 Fed. Reg. at 39225. The preamble to the rule, but not the rule itself, states that applicants "should not be made eligible until they have presented the required evidence." 71 Fed. Reg. at 39216.

There is no statutory basis for this statement. The DRA is silent as to when federal matching funds will be available to states for Medicaid services furnished to applicants who establish their eligibility for Medicaid, but, despite good faith efforts, have not been able to obtain the required documentation. Moreover, documentation of citizenship, while a requirement for enrollment resulting from the DRA, is not a requirement for Medicaid eligibility.

If the rule is implemented, children who are U.S. citizens who meet all of the state's eligibility criteria, but whose parents or guardians try, but fail, to obtain the necessary documentation, will be denied Medicaid coverage. As an example, those children whose birth certificates were destroyed by Hurricane Katrina and have no other way to prove their citizenship will simply be denied coverage and may be in a position to never receive services under the program.

The rule creates an untenable situation for pediatricians for a number of reasons. First, pediatricians may not receive Medicaid payment for services rendered until their patients' documentation has

been assembled and presented to the state Medicaid agency. If pediatricians request payment for services furnished to applicants in these circumstances, they may deemed to be submitting false claims and subjected to significant legal liability. Second, the rule creates a bad policy result by increasing uncompensated care. Pediatricians who try to balance a private pay population with patients paid for by public funds will find it even more difficult to provide services to the Medicaid population as their proportion of uncompensated care rises. If pediatricians decide instead to forego providing services to the Medicaid population, access to needed health care will decline.

We urge CMS to revise 42 CFR 435.407(j) to clarify that applicants who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid. The reasonable opportunity period should then begin for applicants to obtain the documentation required by the rule. Additionally, we urge CMS to revise 42 CFR 435.1008 to clarify that, consistent with current CMS regulations at 42 CFR 435.914, eligibility for such applicants is effective the third month before the month of application through the expiration of the "reasonable opportunity" period. In the absence of this clarification, states and pediatricians will have no assurance that federal Medicaid matching funds are available for medically necessary covered services. Finally, AAP urges CMS to add children to the list of vulnerable groups that states must assist in accessing necessary documents.

Children in Foster Care

The interim final rule applies the DRA citizenship documentation requirements to all U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. Among the children subject to the documentation requirements are those in foster care, including those receiving federal foster care assistance under Title IV-E. It is unreasonable to expect foster children and foster parents who did not receive proper identification from foster care services to obtain such documentation.

Under current Administration for Children and Families (ACF) policy, state child welfare agencies must verify the citizenship status of all foster care children in the process of determining eligibility for Title IV-E payments. Nonetheless, the preamble to the rule states that these Title IV-E children receiving Medicaid "must have in their Medicaid file a declaration of citizenship ... and documentary evidence of the citizenship ... claimed on the declaration." 71 Fed. Reg. at 39216. CMS should clarify that foster care children should be treated as current beneficiaries rather than applicants for this purpose. There is no language to this effect in either the rule itself or the preamble.

The DRA does not require that foster children be treated as applicants, and thus denied coverage. This CMS interpretation of the DRA creates unnecessary duplication of state agency effort and puts these children at risk of delayed Medicaid coverage. In fact, the DRA stipulates that the citizenship documentation requirement shall not apply to individuals who are eligible for Medicaid "on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented." Section 1903(x)(2)(C) of the Social Security Act. The receipt of Title IV-E payments is precisely such a basis of eligibility, yet CMS has elected not to exempt foster care children receiving such payments from the new documentation requirement. 71 Fed. Reg. at 39216. We urge you to revise 42 CFR 435.1005 to add children

eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirement.

States' Inability to Locate Adequate Documentation

The rule should not penalize legitimate Medicaid beneficiaries if states are unable to locate proof of identification or citizenship. Under the rule, the only individuals exempted from citizenship documentation requirements are Medicare beneficiaries and most SSI beneficiaries. There are U.S. citizens who will have as much, if not more, difficulty obtaining documentation of citizenship but for whom the rule still applies. Among these are victims of natural disasters whose records have been destroyed, and homeless individuals whose records have been lost. The rule directs states to assist individuals with "incapacity of mind or body" to obtain evidence of citizenship, 42 CFR 435.407(g), but it does not address the situation in which a state is unable to locate the necessary documents for such an individual. Nor does the rule address the situation in which an individual does not have "incapacity of mind or body" but his or her documents have been lost or destroyed and, despite the best efforts of the individual or a representative, the documents cannot be obtained. As a result, under the rule if such individuals apply for Medicaid they may never qualify, and if such individuals are current beneficiaries, they will lose their coverage once their "reasonable opportunity" period expires.

As a last resort, the interim final rule allows the use of written affidavits to establish citizenship, but only when primary, secondary, or third-level evidence is unavailable, and "ONLY ... in rare circumstances," 42 CFR 435.407(d)(5). The requirements for these affidavits are rigorous, and it is likely that in a substantial number of cases they will not be met, because two qualified individuals with personal knowledge of the events establishing the applicant's or beneficiary's claim to citizenship cannot be located or do not exist. In short, the rule simply does not recognize the reality that there are significant numbers of U.S. citizens without documents proving citizenship and without any idea that they need documents proving citizenship. Again, the rule will deny coverage to some current Medicaid beneficiaries, even though the last resort of written affidavits has been made available by CMS: some current beneficiaries will not meet the rigorous standards necessary for the submission of these affidavits and will eventually lose their Medicaid coverage once the "reasonable opportunity" period ends.

Additional Burdens on Beneficiaries and States

The rule states that applicants and beneficiaries may not use photocopies or even notarized copies of birth certificates or other documents, and that only originals or copies certified by the issuing agency will be accepted. 71 Fed. Reg. 39216. The utilization of paper, while especially burdensome on state governments, is in direct contravention with stated policy objectives of the federal government to move towards electronic means for data retention. In addition, the requirement for certified copies or originals is costly for Medicaid beneficiaries.

CMS also states that collecting and presenting documentation of citizenship and identity will only take beneficiaries 10 minutes, and that it will take states 5 minutes to obtain acceptable documentation, verify citizenship and maintain records (see "Collection of Information Requirements" at 71 Fed. Reg. At 39220). On its face, this estimate appears to be grossly in error.

Additionally, the requirement that states conduct a social security number match, which appears in the preamble, but not in the regulation, provides yet another hurdle for states and beneficiaries. Beyond the burden on states to collect and verify social security numbers, some beneficiaries may be subject to mistakes in the Social Security system, and thus be denied needed care purely as a result of bureaucracy. Also, children are not automatically given social security numbers. Social Security numbers are not issued until a parent of a child submits an application requesting a number. Thus, states may lose the federal match for services rendered to children who may not yet have social security numbers but whose parents provide an affidavit as to their identity. This may unwittingly encompass many of the children that the Medicaid program is designed to serve.

Positive Aspects of the Rule

AAP commends CMS for a number of provisions in the rule. First, use of the SDX system appears to be a positive aspect of the regulation that may make it easier to prove some Medicaid beneficiaries qualify. The addition of an affidavit allowed for purposes of establishing identity for children under 16 (42 CFR 435.407(f)) is another positive provision. It is also positive that CMS indicates that individuals may submit documents by mail or other means. Finally, AAP appreciates that presumptive eligibility is preserved under the rule.

Conclusion

The purpose of the DRA citizenship documentation requirements is to ensure that individuals receiving non-emergency Medicaid benefits are U.S. citizens or nationals or legal immigrants not subject to the five-year bar. Because the Medicaid population subject to these requirements is by definition vulnerable - the large majority are children under 18 in low-income families - documentation requirements that appear reasonable in an affluent population may have unintended effects when applied to Medicaid applicants and current beneficiaries. The rule acknowledges this reality with respect to Medicaid beneficiaries and many SSI recipients, but it does not effectively address the situation of most newborns, applicants, children in foster care, and those for whom documents are unavailable through no fault of their own. Unless serious revisions are made, a reduction in the accessibility and quality of care for the low-income children Medicaid was intended to protect will result.

Sincerely,

Eileen M. Ouellette, M.D., J.D. FAAP

Eileen M. Ouellette, MD, JD, FAAP
President

Children's Hospital and Health System™

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July 31, 2006

Centers for Medicare and Medicaid Services,
Office of Strategic Operations and Regulatory Affairs,
Regulations Development Group,
Attn: Melissa Musotto, CMS-2257-IFC,
Room C4-26-05, 7500 Security Boulevard,
Baltimore, MD 21244-1850

Attn: CMS-2257-IFC
Medicaid Program; Citizenship Documentation Requirements

Dear Sir/Madam:

On behalf of the children in our community served by Medicaid, Children's Hospital if Wisconsin is pleased to provide comments to the Centers for Medicare and Medicaid Services (CMS) on its Medicaid citizenship documentation interim final rule published in the July 12 *Federal Register.* These rules implement section 6036 of the Deficit Reduction Act of 2005 (DRA). We commend CMS on the effort evident in formulating these very significant regulations within a very short time.

The policies set forth in the regulation could have a very significant impact on our hospital and the patients we serve. Medicaid provides an important safety net that allows children to access critical medical services. Without modifications, these regulations may impose significant barriers to children in our community in obtaining Medicaid coverage, which could delay or prevent them from receiving necessary care. They may also impose an undue financial burden on children's hospitals, which will not be compensated for care they provide to children otherwise eligible for Medicaid until the documentation requirements are satisfied.

As we are the only free-standing children's hospital in the state of Wisconsin, the Medicaid program is extremely important to Children's Hospital of Wisconsin and to the patients we serve. In 2005, Children's Hospital of Wisconsin had 67,495 total inpatient days. Of this, 32,427, or 48%, were provided to individuals covered by Medicaid. In Southeastern Wisconsin, almost 40% of all Medicaid-covered inpatient admissions for patients age 0-17 are provided at Children's Hospital of Wisconsin. Excluding maternity, newborns and neonatal services, Children's Hospital of Wisconsin provided almost 90% of the Medicaid-covered inpatient admission in Southeastern Wisconsin.

The proposed regulations and the underlying law require a very delicate balancing act. On the one hand, they seek to ensure that individuals without legal eligibility do not receive services for which

they are not entitled. On the other hand, if not implemented extremely carefully, the policy and underlying rules will create a major barrier to the ability of literally millions of children to receive timely care, placing them at increased risk of serious health problems and placing children's hospitals, which are disproportionately devoted to children, at serious financial risk for caring for them without Medicaid coverage.

We want both to commend CMS for some positive changes that were made in the interim final rule that will benefit children and to discuss the strong concerns we nonetheless continue to have.

The positive changes include the exemption of SSI children, clarification that presumptive eligibility is still intact for children, and explanation that states are allowed to do data matches with vital statistics to access birth records are significant, positive changes that will lessen the impact of these new requirements on children's ability to access and retain Medicaid services. Each will ensure children in need receive Medicaid coverage on a timely basis, without undermining the purpose of the citizen documentation requirements.

At the same time, we must also express our strong concern about the regulation and its potentially serious impact on our hospital and the children we serve. Our main comments are:

Exemption for Children
The law's enactment clearly does not reflect the reality that children represent more than half of all Medicaid recipients and face the greatest risk of inappropriate denial of needed health care if the law becomes a barrier to timely enrollment. Children should be exempted from the documentation requirements. Studies have shown that when states change eligibility requirements for children, enrollment drastically decreases. The documentation requirements contained in these regulations represent barriers that are likely to add to the six million children who already are eligible for Medicaid but not enrolled. We recognize that CMS does not currently have statutory authority to exempt children; however, we strongly encourage CMS to work with Congress to accomplish this policy change.

Until Congress is persuaded to amend federal statute to exempt children from the DRA's document requirements, we recommend that as an interim step CMS exempt children who are eligible for federal foster care payments from documentation requirements. It is our understanding these children already provide documentation to prove citizenship through the foster care eligibility process; double presentation of documentation is unnecessary. In addition, we ask that CMS add children to the list of vulnerable groups that states must assist in accessing necessary documents.

Document Requirements
We strongly recommend that CMS allow states to accept copies or notarized copies of required documentation. The requirement that documents be originals or a certified copy from the issuing agency institutes an unnecessary barrier for children and families applying for Medicaid. States have

streamlined their application processes to increase the number of eligible children enrolled in Medicaid, including eliminating requirements for face-to-face interviews. Although states are authorized by the rule to accept documents by mail, it is unlikely that families will choose to submit such important documents by mail. This will result in an increase in face-to-face interviews at state Medicaid agencies and likely a potentially significant decline in Medicaid enrollment among eligible children.

Provision of Benefits to Medicaid Applicants
We recommend that CMS treat children applying for Medicaid who meet other eligibility criteria as Medicaid recipients. This would allow children applying for Medicaid to receive needed medical benefits while the family produces the appropriate documentation and ensure pediatric providers would be reimbursed for these services.

Application to Newborns
The preamble to these regulations states that newborns whose mothers are categorically eligible for Medicaid are deemed eligible and do not need to have citizenship documented until their first redetermination period. Although we support this clarification, CMS should amend its list of acceptable documents to include a state Medicaid agency's record of payment for these children. When Medicaid has paid for the birth of a child in a U.S. hospital, the child is by definition a U.S. citizen. Requiring Medicaid agencies to obtain additional documentation is unnecessary and redundant. Since birth certificates can take months to obtain, children's hospitals are at high risk for delayed or denied payments for often-expensive treatment of low-birthweight babies and those with post-partum complications.

Conclusion
Because they represent more than half of all Medicaid recipients and depend upon adults to act for them, children are an especially vulnerable population that is likely to be significantly adversely affected by the barriers to Medicaid coverage these documentation requirements impose. The delay in eligibility determination for children who apply for Medicaid will also result in delayed or denied payments for the children's hospitals who serve these children, thereby jeopardizing the financial ability of children's hospitals to serve all children, no matter their insurance status or family income.

We appreciate the opportunity to present our comments and would be pleased to discuss them further. For additional information, please contact me at (414) 266-6328 or mrakowski@chw.org. Thank you for your consideration.

Sincerely,

Mark Rakowski
Director Managed Care

National Association of
Community Health Centers, Inc.®

August 7, 2006

Centers for Medicare and Medicaid Services
U. S. Department of Health and Human Services
Att: CMS-2257-IFC
Mail Stop C4-26-05
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Baltimore, MD 21244-1850

Re: CMS-2257-IFC
Interim Final Rule on Medicaid Program: Citizenship Documentation Requirements
RIN 0938-A051
71 Fed. Reg. 39214, et seq. (July 12, 2006).

Dear Sir/Madam:

The National Association of Community Health Centers ("NACHC") is submitting these comments regarding CMS's interim final rule implementing the Medicaid Citizenship Documentation requirements of section 6036 of the Deficit Reduction Act of 2005 ("DRA") (Pub. L.109-171). NACHC is a membership organization representing Federally Qualified Health Centers (FQHCs) nationally. At present, more than 1,000 FQHCs with more than 5,000 sites serve approximately 15 million patients across the country, the vast majority of whom are impoverished individuals living in medically underserved areas. More than 5.5 million of these FQHC patients are Medicaid recipients.

Beyond the serious impact that these new rules will have on the nearly 60 million Americans who rely on Medicaid today as their only affordable source of health coverage, the rules will have a significant effect on the availability of care for other Americans as well. The loss or denial of Medicaid benefits for individuals who are clearly eligible, but are unable to verify (or to timely verify) their U.S. citizenship, will have a serious adverse impact on the ability of FQHCs to serve their overwhelmingly low-income patients. FQHCs – due both to their mission and to the conditions of the grants they receive under Section 330 of the Public Health Service Act – must make their care available to everyone in their service areas regardless of ability to pay. Thus, FQHCs are obligated to continue to provide primary and preventive care services to their **current** patients who may lose Medicaid coverage because they cannot document that they are citizens. They are also obligated to serve any **new** patients who may lose Medicaid coverage, due to their inability to document their citizenship, and who seek

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care from them because they can no longer afford to receive care from their current non-FQHC providers. Caring for these individuals will further strain the ability of FQHCs to meet the needs of their local communities, forcing them to use the federal PHS Act grants that the Congress has provided to support care to the increasing number of uninsured persons who are not categorically eligible for Medicaid to instead serve those individuals.

NACHC clearly recognizes that CMS is obligated to implement the citizenship documentation requirements mandated in Section 6036 of the DRA. **The general thrust of our comments, however, is that CMS should permit as much flexibility as can reasonably be allowed under the statute, and should take the most pragmatic approach possible, to assure that the millions of current recipients and new applicants impacted by this law have the broadest opportunity to meet the requirements of the statute without losing or being denied coverage as they endeavor to do so.** We see CMS's conclusion that Medicare and SSI recipients need not present additional citizenship documentation as an excellent example of such an approach. Similarly, CMS's decision to permit vital records matching in order to secure proof of citizenship, as well as the agency's clarification regarding the extent to which state Medicaid agencies can consult with other public agencies in order to secure evidence of citizenship and identity, meets that standard and thus earns our strong support. On the other hand, there are several aspects of the rule where we believe CMS's approach falls short of that mark and should be reconsidered.

Foster Care Children

The interim rules do not exempt children in foster care from the citizenship documentation requirements, including those who receive federal foster care payments under Title IV-E. However, state child welfare agencies must verify the citizenship of foster care children when determining their eligibility and those found eligible for that program are automatically eligible for Medicaid. Other children may be found eligible for Medicaid through other coverage categories. Nonetheless, the preamble to the rule states that these children must have a declaration of citizenship in their Medicaid file as well as documentary evidence of such citizenship 71 Fed. Reg. at 39216. This policy – which appears to be wholly at odds with the decision exempting Medicare and SSI beneficiaries from these rules – would require unnecessary duplication of state agency efforts and put children at risk of delayed, or even denied, Medicaid coverage. Finally, it is our understanding that CMS staff has indicated that Title-IV foster care children **will be** treated as Medicaid recipients for purposes of the citizenship requirements. The finalized version of the rule, therefore, should clearly exempt foster care children from the documentation requirement

Medical Records of Birth

Under current law, children born in the United States are U. S. citizens, including those born to undocumented pregnant women (for whom Medicaid is available only for coverage of the labor and delivery of the child.). CMS' interim regulations do not permit a State to consider a record of Medicaid or other insurance payment for the birth of the

child in a U.S. hospital as acceptable documentation of the child's citizenship. We believe such an approach is totally illogical. If Medicaid has covered a child's birth in a hospital in the United States, the records of such payment serve as clear and incontrovertible evidence that the child is a U. S. citizen. We urge CMS to permit such records of payment by Medicaid (or any other insurance payment for birth in a U.S. hospital) as sufficient proof of U.S. citizenship.

Acceptable Documents to Establish Identity

The interim final rule accepts in part the recommendation that NACHC suggested in its May 12, 2006 letter to Dr. McClellan, on the need to expand the kinds of documents that would be sufficient to establish identity for Medicaid. The new 42 CFR 435.407(e) provides that identity can be established by various documents, including a school identification card with a photograph, a U.S. military card or draft record, a military dependent's identification card, or a Native American Tribal document (regarding this last example, new 42 CFR 407(e)(6) should be amended in the final rule to clarify that this includes tribal enrollment cards.) We renew our recommendation that in the final rule other documents – such as a voter registration card, school records or report cards, or a clinical doctor or hospital record – should be accepted as sufficient to establish identity.

Submission of Original Documents

While the interim final rule encourages states to use existing state and federal data bases, we regret that the new 42 CFR 435.407(h)(1) requires applicants to submit **original or certified documents**, rather than copies or notarized copies. The DRA does **not** require the provision of original or certified documents exclusively, nor should the final rule contain this burdensome requirement.

Documentation Dates

In several parts of its rule – specifically 42 CFR 435.407 (c) and (d) and 436.407 (c) and (d) – CMS requires that, in order for certain documents to qualify as evidence of citizenship, they must have been created at least five years before the initial Medicaid application date. **Notably, clinic records are listed as one of those documents that must meet the five year rule.** NACHC believes that this five year requirement undercuts the effectiveness of such a rule and will certainly limit the ability of FQHCs and other healthcare providers to assist their patients in documenting their citizenship through such medical records. Such a five year requirement is not provided for in the statute and appears to be an arbitrary standard that will establish an unnecessary obstacle for health center patients and other individuals to surmount in order to qualify for Medicaid services.

Reasonable Opportunity for New Applicants

We are pleased that the final interim rule gives current Medicaid beneficiaries a reasonable opportunity to provide the necessary documents when they renew their Medicaid status, including provisions for continued Medicaid coverage while a current Medicaid beneficiary appeals an adverse eligibility decision. States should be provided broad discretion to allow **current recipients** the necessary time to collect their proof of citizenship. We also recommend that the final rule require states to enroll **new applicants** who otherwise meet Medicaid eligibility requirements while they, too, are given a reasonable opportunity to document their self-attestation that they are citizens. In the preamble to the interim final rule, CMS estimates that the prior self-attestation system for citizens led to less than $120 million a year in potential Medicaid fraud, or less the 0.0005% (1/50th of 1 percent) in total Medicaid spending 71 Fed. Reg. 39221. Thus, the new documentation system, even if it works perfectly in preventing Medicaid fraud by beneficiaries, will save less than $120 million annually, whereas the cost of compliance with such requirements may very well exceed the potential savings. Rather than deny citizens the Medicaid care to which they are entitled, CMS should amend new 42 CFR 435.407(j) to permit new applicants to enroll in Medicaid while also being given a reasonable opportunity to provide the necessary documentation in support of their self-attestation.

Populations Requiring Special Assistance

We also strongly recommend that the final rule contain more detail as to the populations that will require special assistance and the minimal steps the states must take to assist them. For example, while the preamble to the rule indicates that assistance in securing necessary documents should be provided to homeless persons, the rule itself – at 42 CFR 435.407(g) and 436.407(g) – does not mention the homeless. **FQHCs throughout the country serve nearly 680,000 homeless patients,** and can attest to the fact that it will be very difficult for these individuals, with no fixed address, little or no income, and often in very poor health, to secure necessary documentation of citizenship.

We also believe that it is critical that CMS recognize in its rule and policy that when people have been displaced by natural or man-made disasters, it will be particularly difficult for them to produce citizenship documentation. Recently, FQHCs across the country provided health care for at least 70,000 victims of Hurricanes Katrina and Rita. They can attest to the fact that these patients, in most cases, arrived with only "the shirts on their backs," and that whatever documents they might have possessed or had access to prior to the storms had been destroyed. Indeed, in a number of cases, the FQHCs themselves have suffered great damage from the hurricanes, and have lost patients' medical records as a result. It seems obvious that any rules regarding citizenship documentation must factor in and make provision for victims of natural or man–made disasters. While FQHCs will of course serve these patients, they – and other providers who respond to such emergencies – should be able to receive Medicaid reimbursement for those who are able to qualify for Medicaid except for their ability to document that they are citizens.

FQHC Participation in Outreach Efforts

CMS maintains that it "has launched an outreach program to educate states and interested groups about the new requirement" (July 6, 2006 Medicaid Fact Sheet at 5). We, of course, applaud such an effort and **request that CMS strongly recommend to the states that they enter into arrangements with health centers so that centers can assist in expediting the citizenship documentation process on site.** Since 1991, federal Medicaid law has required that states outstation Medicaid eligibility workers at FQHCs, and CMS rules have recognized that states can receive Medicaid administrative matching funds for the costs they incur in reimbursing FQHCs when FQHC staff carry out such outstationing activities in place of, and per agreement with, the state Medicaid agency (42 USC 1396a(a)(55) and 42 CFR 435.904). Coordinated efforts between state Medicaid agencies and FQHCs in assisting individuals to document their citizenship are a natural extension of the statutory outstationing mandate. In this context, we believe that the final rule should clarify that assistance in the collection of citizenship documents is part of the initial processing requirements that must be in place at all Medicaid outstationing locations; the rule should also clarify the circumstances under which FFP not only can be available but in fact must be available.

A State Should Be Required to Accept the Determination of another State that a Medicaid Applicant Is a Citizen

New section 435.407(h)(5) provides that "Presentation of documentary evidence of citizenship is a one time activity." However, the interim final regulation and its preamble fail to acknowledge that Medicaid beneficiaries, like other citizens, move among the states. A person who has provided adequate citizenship and identity documentation to one state should not be required to provide similar documentation to another state. Thus, new section 435.407(h)(5) should be amended to provide that any state should be expected, even required, to accept the determination by another state (unless it can show that fraud was committed relating to the determination in the first state).

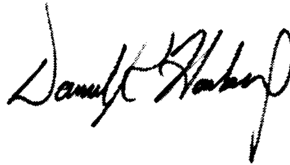
The Final Rule Should Be Revised to Reflect the Policy Regarding Presumptive Eligibility Articulated in the Preamble to the Interim Final Rule.

The preamble to the interim final rule provides that –

> "Individuals who receive Medicaid because of a determination by a qualified provider, or entity, under sections 1920 [pregnant women], 1920A [children], or 1920B [certain breast cancer or cervical cancer patients] of the [Social Security] Act are not subject to the documentation requirements until they file an application [for Medicaid] and declare on the application that they are citizens or nationals. These individuals receive Medicaid during the 'presumptive' period notwithstanding any other provision of title XIX [of the Social Security Act]..." 71 Fed. Reg. 39216.

This very important and positive policy on presumptive Medicaid eligibility for these three groups is not included in the actual interim final regulations. The final regulations should correct this important oversight and include that policy in rule.

Respectfully submitted,



Daniel R. Hawkins, Jr.
Vce President for Federal, State, and Public Affairs

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

August 7, 2006

Mark B. McClellan, M.D., Ph.D
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attn: CMS 2257-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicaid Citizenship Documentation Provisions of the Interim Final Rule with Comment Period, Regulatory Impact Statement 71 Federal Register 39214 (July 12, 2006); File Code CMS-2257-IFC

Dear Dr. McClellan:

The American Public Human Services Association (APHSA) and its affiliate, the National Association of State Medicaid Directors (NASMD), respectfully submit this comment letter on Medicaid; Citizenship Documentation Requirements. APHSA is commenting on the interim final rule that was published on July 12, 2006, in the *Federal Register* (71 FR 39214) for the Centers for Medicare and Medicaid Services (CMS).

APHSA appreciates the opportunity to work with CMS in the initial phase of implementation of this important provision as required by the Deficit Reduction Act of 2005. States have and will continue to make a good faith effort to comply with the statute in a timely fashion. As discussed in greater detail in our comments below, states believe that there are several steps CMS can take to clarify its guidance and minimize the burden on both states and current and potential Medicaid consumers while still fulfilling the intent of the law. We further believe the regulation should more closely follow the statute.

States request that CMS exempt foster care youth, independent living youth, subsidized adoption Medicaid recipients, and individuals receiving Social Security Disability Income (SSDI) from this requirement. In addition, there are several recommendations that APHSA believes will streamline the documentation process while more closely following the statute. Such recommendations include: remove the "tiered" approach to the acceptable documents list, amending the types of documents currently accepted, and addressing the resource burden this mandate imposes on states.

Amending Requirements for Special Population Groups

APHSA commends CMS for determining that there was a scrivener's error and that Supplemental Security Income (SSI) and Medicare recipients are exempt from both the citizenship and identity requirements. In addition, we request that the exemption be extended to additional population groups: foster care children, subsidized adoption Medicaid recipients, and independent living youth and individuals receiving Social Security Disability Income (SSDI).

Foster Care Children

Through their child welfare agencies, States routinely determine citizenship for all children in foster care, regardless of Title IV-E eligibility. After the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (PL 104-193), the Administration for Children and Families (ACF) issued a Policy Interpretation Question (PIQ) on January 14, 1999 which, explicitly indicates that states are <u>required</u> to verify the citizenship of all children receiving federal foster care maintenance payments, adoption assistance payments or independent living services. Because a state does not know if a child is eligible for Title IV-E at the time the child enters the system, the child welfare agency must verify citizenship of all children entering the foster care system.

With regard to identity, most children in foster care simply do not have access to the documents outlined in the interim final rule. Given the contentious nature of the removal of a child, it is unlikely that the parent(s) will be willing or able to provide the necessary identification documents to the state. Therefore, APHSA strongly recommends that this population be exempt from these requirements.

<u>*Applicant and Recipient Status*</u>

In addition, in previous forums CMS has verbally communicated that children in foster care, children receiving adoption assistance, and independent living youth who are categorically eligible for Medicaid, are to be treated as recipients, not applicants, for purposes of citizenship documentation. APHSA appreciates this statement. However, states believe they currently lack the legal standing to apply this distinction. As such, APHSA requests that CMS provide official written guidance explicitly indicating that these categorically eligible children are to be treated as recipients. In order to expedite this request, we are asking that a Dear State Medicaid Director letter be issued in the immediate future. We also request that the language regarding recipient versus applicant be clarified in the final regulation.

Newborn Children

In accordance with the Social Security Act §1902, §1903(v), and 42 U.S.C. §1396(e), an infant born to a non-citizen pregnant mother whose labor and delivery are covered by Medicaid is born to a woman eligible for and receiving medical assistance (emergency services) under a State plan. Therefore, we request that these infants be deemed eligible for Medicaid for a period of one year.

Supplemental Security Income and Social Security Disability Income Beneficiaries

We also ask that individuals who are receiving Supplemental Security Income (SSI), but have not yet been entered into the database system, be permitted to provide SSI check stubs to document that they are in fact SSI recipients. SSI recipients in all states should be treated the same regardless of whether they live in a 209-B state or a 1634 state because Social Security Administration (SSA) has established citizenship and identity for all recipients of SSI. In addition, we request that CMS clarify that former Medicare and SSI recipients are exempt from this requirement.

We further contend that the application process and documentation requirements for SSI are identical to that for Social Security Disability Income (SSDI). As such, SSDI recipients should be treated similarly and therefore be exempt from the requirement to document citizenship and identity.

Tribal Members

States also are concerned that the interim final rule does not allow for the acceptance of tribal enrollment cards as proof of citizenship. APHSA and the states have worked closely with tribes on this issue, and we believe the processes for obtaining a tribal enrollment card go well beyond the burden of proof for documenting citizenship for the Medicaid program and should therefore be acceptable as proof of citizenship.

Although the process may differ between tribes, all tribes base the tribal enrollment card process on ancestry. Specifically, many base it on being able to prove that an ancestor's name was part of a tribal enrollment treaty such as the Dawes Commission rolls for enrollment between 1899 and 1906; the Grande Ronde Restoration Act and subsequent *Federal Register* announcement on June 24, 1984 that listed tribal members; the Alaska Native Claims Settlement Act of 1971; the Annuity Rolls of April 14, 1941 for the Minnesota Chippewa Tribe; and others. APHSA also has learned that many processes require a birth certificate, affidavit of paternity, documentation of blood line, and other similar ancestry documentation.

In addition, APHSA recognizes that there are concerns with individuals who may be members of tribes located in States having an international border. However, we believe it would be more reasonable for CMS to provide additional guidance specifically directed towards such tribes.

Expanding Acceptable Documentation

APHSA appreciates CMS's efforts to approve a range of documents as acceptable for meeting the citizenship and identity requirements. States have reviewed the types of information collection, records, and current systems and believe there are additional forms and methods for documentation that should be accepted as proof of both citizenship and identity. The documents listed below would strengthen states' ability to accurately document proof of citizenship and identity. We also recommend that CMS develop a process by which states can submit requests for additional documents that also meet these requirements but have not yet been identified or are subsequently developed.

Citizenship

Specifically, on citizenship documentation we request that CMS allow states to accept the following documents:

- Copies of birth records, or souvenir birth certificates, submitted by hospitals to States' Vital Records Bureau for registering births.
- States' Medicaid paid claim forms for births.
- Birth records from child support agencies.
- Tribal enrollment cards. Enrollment in a federally recognized tribe should also be acceptable to document citizenship. The Native American Tribal documents listed as documentation of identity should also be accepted for citizenship.
- State identification cards.
- The "preponderance of evidence." This should be allowable in rare situations where exhaustive research has been done and everything points to citizenship, but none of the listed documents exist. APHSA has heard that states have done this in the past, and it has not later been proven to result in erroneous citizenship documentation.

In addition, the following records are currently permissible forms of secondary evidence for citizenship verification from the SSA Programs Operation Manual System (POMS). As such we request that CMS also allow these records for purposes of meeting the Medicaid citizenship documentation requirement.

- A religious record established in the U.S. within 3 months of birth, showing a U.S. place of birth and either a date of birth or the individual's age when the record was made.

- An early school record for the applicant showing a U.S. place of birth, the date of admission to school, the date of birth, or the age of the individual at the time the record was made, and the names and places of birth for the applicant's parents.

Identity

For purposes of identity, we request that the following additional items be allowed:

- Birth certificates. These certificates specifically identify all necessary information that other identity documents contain.

- Voter registration cards. These are government issued cards that meet the necessary requirements to reliably prove identity.

- A child's removal court order and court documents for individuals of any age.

- Verification of identity by Child Welfare agencies for children under their care.

- Birth records from child support agencies.

- Immunization records. These records contain identifying information, specifically for children. States have found that parents are more likely to retain immunization records than other types of documentation.

- Private agency identification cards for children. Most of these, such as I-Dent-A-Kid and Life Touch, work with school systems.

- Photos in school yearbooks should be permitted as they identify children under 18 who are enrolled in school.

- School records for children under 18.

- Identity affidavits or facility medical records for any institutionalized individuals who are not receiving SSI or Medicare.

- Social Security (NUMIDENT) System.

- Checks issued by the U.S. Department of Veteran Affairs.

- Affidavits. These should be permitted to prove identity for individuals of all ages.

Data Matches

APHSA appreciates the opportunity to recommend additional data match sources that should be permissible for citizenship and identity. States request that CMS make the following data match sources acceptable:

- Matches with the Public Assistance Recipient Information System (PARIS).
- Matches with NUMIDENT.
- Matches with the U.S. Department of Veterans Affairs.
- Medicaid paid claim forms that show that Medicaid paid for the birth.
- Matches with the Social Security Administration's SS5 database.
- Matches with the U.S. Citizenship and Immigration Services (CIS) database, Systematic Alien Verification for Entitlements (SAVE).
- Matches with Indian Health Services.
- Matches with State Attorney General offices.

Interstate Transfer of Information

APHSA requests that CMS clarify that an inter-agency data match is sufficient and no additional documentation is necessary. Specifically, we ask that CMS permit as sufficient proof an intra-state data match with the department of motor vehicles or vital statistics offices. Also, in light of the fact that many states are moving to paperless case files, we ask that you accept an indicator on an electronic case file rather than require states to keep "paper" case files.

In addition, states are concerned with the treatment of inter-state transfers in the interim final rule since such transfers will be critical components of the processes states establish to meet the documentation requirements. To meet this requirement, APHSA recommends that states be allowed to request copies of documentation from another state's Medicaid agency. Additionally, APHSA requests that if one state has verified the citizenship or legal status of a Medicaid client, then that documentation should be acceptable in all states without holding any states liable for federal penalty for failure to document citizenship a second time. That is, if the client moves from state A and applies for Medicaid in state B, the documentation from state A should suffice and state B should be held harmless for disallowances made by CMS for any subsequently identified eligibility errors based on information from state A.

States will utilize a range of databases to comply with this regulation. Further, states are continuously upgrading their systems and new databases are periodically developed. As such, we recommend that CMS provide additional information regarding acceptable database sources. APHSA also requests that CMS work with states to identify a process for determining the reliability of new databases as they become available and when they can be used to document citizenship and identity in accordance with this regulation.

Reducing the States' Burden of Administering Large Federal Mandates

APHSA is concerned that CMS has vastly underestimated the burden to states. States have received limited outreach guidance from CMS, yet they have had to provide training for eligibility workers and other staff, and even other state agencies, whose responsibilities require them to be knowledgeable of this new requirement. They also have had to develop new materials and systems. To this end, we recommend that the agency consult with states to develop an accurate estimate of the additional costs and requirements of this new mandate to states. States also request that they receive a higher FMAP to accommodate this significant new responsibility.

In addition, states believe CMS has failed to provide an accurate estimate of the time and resources that states are and will continue to invest in obtaining, documenting, and, in some cases paying for, the required documents. Several states have estimated their time frame to be between twenty and twenty-five minutes per recipient, clearly much longer then the five minute estimate in the regulation. States are further reporting that the time it takes an individual to acquire and provide the state with acceptable documentary evidence and to review the declaration is considerably longer then the ten minutes allocated in the interim final rule.

Implementation Considerations

APHSA requests that CMS alter the language to treat applicants and recipients equally. We request during the reasonable period, CMS allow the applicants who have declared they are citizens to qualify for Medicaid services.

Further, APHSA requests that citizens be given the same rights as applicants who declare they are immigrants. States are mandated to provide a person who declares that they are a legal immigrant (who has been in the U.S. over 5 years) eligibility for Medicaid without their documentation. According to 42 U.S.C. §1320b-7(d)(4)(A), states also are mandated to make immigrants eligible for Medicaid and to provide them with a reasonable opportunity period to submit satisfactory immigration information. We ask that states be permitted to provide individuals who declare they are citizens with eligibility during the reasonable opportunity period while they obtain the documentation. Further, we request that states be eligible to receive Federal Financial Participation (FFP) for providing services to such individuals during this time period.

Most states define a minor as an individual under the age of 18 or 21. We request that states be afforded the option to apply the criteria for youths age 17 that they would apply for those aged 16 and under.

Federal Financial Participation for Administrative Expenditures

APHSA respectfully requests an expansion of the definition of administrative expenditures for which states can receive FFP. APHSA recommends that CMS revise the definition for administrative expenditures to include personnel, costs to obtain records for those clients who are impoverished, and costs for the development of database interfaces.

Further, we ask for clarification for individuals found to be presumptively eligible who subsequently are unable to meet the documentation requirements. We ask that states be permitted to collect FFP for the period of presumptive eligibility. States also are working with CMS to comply with the new Payment Error Rate Measurement (PERM) requirements. APHSA strongly recommends that states be held harmless from PERM as long as they can outline the steps taken to obtain proof of citizenship and identity.

We ask that states be reimbursed for Medicaid claims, retroactive to the date of application, for administrative and health services provided to Medicaid applicants whose eligibility determination was delayed due to barriers in obtaining citizenship and/or identification documents.

Compliance

As previously noted, states are currently working with CMS to comply with the new PERM requirements. With regard to compliance for this program, states believe it is critical for the Center for Medicaid State Operations to consult with the PERM staff in the Office of Financial Management regarding the overlap and implementation of both new requirements and mandates to states. We ask that CMS work with the PERM staff to outline the PERM requirements and standards as they relate to this provision.

Provisions of the Interim Final Rule with Comment Period

APHSA respectfully requests that CMS remove the requirement for a hierarchy of reliability of citizenship documents since this was not included in the statute of the Deficit Reduction Act of 2005.

Secondary Evidence of Citizenship

We ask for further clarification for children born overseas who are adopted by U.S. citizens. These children and their adoptive parents may not have immediate access to a

certificate of naturalization or a certificate of citizenship. We therefore request that these children be made eligible immediately upon adoption.

Fourth Level Evidence of Citizenship

APHSA appreciates CMS' allowance of affidavits, however we request clarification as to whether the affidavits attesting to the person's citizenship can also be used to document identity. The affiants are attesting to the person's citizenship, therefore it should be reasonable to assume that the individual attesting to the person's citizenship can also attest to the person's identity.

We are asking that the language regarding affidavits be modified to provide the state flexibility to accept a declaration attesting to the facts and given under penalty of perjury. This will allow states that have different requirements for what should be included in an affidavit to obtain the necessary information without changing their statute.

Additionally, we ask for an exception for those individuals that are not incapacitated and have made their best efforts to locate such documents but such documents have been lost or destroyed due to a natural disaster.

States also believe there are alternatives for programs that currently operate on a mail-in basis. States and the federal government have worked together to streamline the process for applying for public assistance program. As a result, many programs have mail-in application processes which do not require a face-to-face interview. We request that if the state can assure that the information received about the identity and citizenship is accurate, copies will be sufficient.

Regulatory Impact Statement

APHSA asks for clarification on the cost to states, and the way in which it has been determined that this provision will yield savings to the states. The regulation specifically states, "state savings under $50 million per year over the next 5 years." Given the significant new requirements for states discussed above in the section on burden estimates, we do not anticipate that states will recognize any savings. Instead, states currently report that they will likely incur significant new costs.

In the Regulatory Impact Statement, a Certificate of Naturalization is listed as an acceptable form of documentation. It has come to the attention of the states that the copying of a Certificate of Naturalization is a felony. Thus, we would request further clarification as to how an agency can appropriately document that such agency has seen the document.

Also included within the regulatory requirements section of the interim final rule are a number of indications that a five-year rule applies. We ask that this requirement be removed.

We would be pleased to meet with you at any time on these matters. Thank you for considering our comments. If you have any questions, please do not hesitate to contact me or Elaine Ryan at (202) 682-0100, ext. 235.

Sincerely,

Jerry W. Friedman
Executive Director
APHSA

Nancy Atkins
Director
NASMD

cc: Melissa Musotto, Office of Strategic Operations and Regulatory Affairs
Katherine T. Astrich, Office of Information & Regulatory Affairs

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER

SCHOOL OF PUBLIC HEALTH & HEALTH SERVICES

DEPARTMENT OF HEALTH POLICY

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Centers for Medicare and Medicaid Services
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Baltimore, MD 21244-8017

Re: Medicaid Citizenship Documentation
Interim Final Rule 71 Fed. Reg. 39214

August 5, 2006

Gentlepersons;

These comments to the above-captioned rule are hereby submitted by the faculty and staff of the George Washington University School of Public Health and Health Services, Department of Health Policy whose names appear at the end of this letter. These comments represent the views of the undersigned faculty and research staff and not those of the George Washington University or the School of Public Health and Health Services

Statement of Interest

The George Washington University School of Public Health and Health Services is the only school of public health in the nation's capital. The Department of Health Policy, unique among schools of public health, is nationally known for its educational programs in health policy, as well as for the scope and quality of its research. Departmental educational activities can be viewed at http://www.gwumc.edu/sphhs/departments/healthpolicy/, and our research can be viewed at www.gwhealthpolicy.org.

Department faculty and researchers particularly emphasize teaching and research related to racial, ethnic, and socioeconomic disparities in health and health care, as well as the range of policy-related factors associated with these disparities, such as poverty and its effects, community health risk, and the lack of financial access to clinically appropriate health care of high quality. Many of the Department's faculty and staff are considered experts in the field of health and health care disparities; indeed, many of us have conducted research projects focused on these issues for the United States Department of Health and Human Services.

Medicaid now reaches more than 55 million low income and at-risk children and adults, who depend on the program to finance the right care, in the right setting, and at the right time, as the Institute of Medicine has so aptly put it.[1] For this reason, we have focused with particular intensity on Medicaid policy, especially policy factors that contribute to barriers to Medicaid

[1] Institute of Medicine, *Crossing the Quality Chasm* (National Academy Press, Washington D.C. 2001)

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eligibility and enrollment and that as a result carry implications for health care access, health care quality and health disparities.

A wealth of health care disparities studies have documented the nexus between Medicaid and health care access and utilization, across many dimensions of care. Documented areas in which Medicaid enrollment has an impact on care are: the appropriate use of preventive, primary, and acute care among infants, young children, and adolescents; access to community-based services in the most integrated setting for children and adults with physical and mental disabilities; the use of pregnancy, child-bearing, and women's health services; use of care among working age adults; and access to care that reduces disparities in health care access and outcomes faced by minority and low income persons.

Medicaid's impact on health and health care can hardly be overstated. Perhaps the single most powerful study of Medicaid's impact on racial, ethnic and socioeconomic disparities ever undertaken relates to Medicaid's impact on both national and Black infant mortality rates between 1965 and 1980, as the program literally opened hospital doors to all pregnant women regardless of race, national origin, and socioeconomic status.[2] Numerous studies also have documented the effects of Medicaid documentation and paperwork burdens on program enrollment and retention rates; indeed, in recent years, many states have moved to simplify their application and eligibility redetermination procedures precisely to reduce the risk of enrollment barriers.

Our research also focuses on the relationship between -- and the impact of -- Medicaid revenues on the stability of critical community-based providers and health systems, such as health centers, public hospitals, public health agencies, Ryan White Care Act providers, community mental health providers, and specialized care providers and programs such as children's hospitals and community systems for children and adults with serious and chronic physical and mental health conditions. Collectively these providers (often referred to as the health care safety net) furnish a disproportionate amount of the health care available to low income children and adults, particularly minority patients and patients with special health care needs. Many of these providers enjoy a strong reputation for the clinical quality and cultural appropriateness of their health care. For these providers, Medicaid represents the principal source of stable and reliable health care financing; as a result, their short-term and long-term institutional health, as well as their ability to assure clinically appropriate care for both Medicaid patients and low income uninsured populations, depends on Medicaid's performance as an insurer.

Deficit Reduction Act of 2005

The Deficit Reduction Act introduces extensive citizenship documentation requirements for both Medicaid applicants and recipients.[3] The legislation conditions federal financial participation for medical assistance on states' ability to furnish "satisfactory documentary evidence" that program

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[2] Karen Davis and Cathy Schoen, *Health and the War on Poverty* (Brookings Institution Press, Washington D.C., 1977).
[3] DRA §6036 Pub. L. 109-171 (109th Cong. 2d Sess.) amending §1903, 42 U.S.C. §1396b(x).

recipients are citizens or legal residents.[4] The legislation requires that both citizenship and identity be documented. In addition, the legislation authorizes the Secretary to identify the range of documents that will be considered as constituting satisfactory evidence.[5]

The documentation provision became effective on July 1, 2006. Initial CMS guidance to states was not available until literally a matter of weeks prior to this effective date. Unlike the implementation of Medicare Part D – a more modest piece of legislation that simply altered the scope of Medicare coverage design rather than potentially implicating coverage entirely – Congress did not provide for a lengthy implementation period. At the same time, Congress did not restrict active Administration outreach efforts to educate communities about the changes.

It is also important to note that the DRA made no similar changes in federal conditions of payment for children covered under the State Children's Health Insurance Program.

The Interim Final Rule

In implementing federal legislative changes that have the potential to fundamentally affect health care financing and access for one sixth of the population, we believe that the correct approach on the part of the Department should be caution and prudence, with an interpretive approach that minimizes the possible impact of changes while adhering to the intent of Congress. This type of cautious approach is especially warranted in this case, because of ambiguities and (in the Department's own words, "scrivener's errors) contained in the DRA.

Positive policy decisions on the part of CMS

Several aspects of the Interim Final rule are worthy of note, because the approach taken is consistent with notion of caution and prudence while at the same time ensuring adherence to Congressional intent. Specifically worthy of note and support are CMS' decision to exempt Medicare beneficiaries and SSI recipients from the new requirements, as well its effort to clarify that the SDX system may be used to obtain necessary documentation in states that do not automatically enroll SSI beneficiaries into Medicaid. With respect to this last point, we recommend that CMS amplify in the final rule the process to be used in undertaking this additional verification step in those states whose Medicaid plans do not provide for automatic SSI beneficiary enrollment. We also caution that SSI beneficiaries could still face exclusion over matters of identity documentation and recommend the development of specific and acceptable procedures for verifying identity.

We also support CMS' decision to permit vital records matching in order to secure proof of citizenship, as well as the agency's clarification regarding the extent to which state Medicaid agencies can consult with other public agencies in order to secure evidence of citizenship and identity.

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[4] 42 U.S.C. §1396b(x)(1), as amended.

[5] 42 U.S.C. §1396b(x)(2)(C), as amended.

Policy decisions by CMS that have the potential to disqualify citizens from Medicaid because of the absence of documentation

At the same time, however, CMS has taken an imprudent approach in our view to various issues raised by the DRA, unnecessarily imperiling coverage for millions of citizens. Children and their parents will feel the most significant impact of these imprudent approaches, since Medicare and SSI populations are largely exempt. Furthermore, given their disproportionate representation among the Medicaid population, minority beneficiaries can be expected to absorb the disparate effects of these decisions. It also should not be forgotten that many beneficiaries with serious and chronic health conditions will feel the impact of the Interim Rule unless revisions are adopted. Half of all children with functional limitations, and a substantial proportion of adults with functional limitations, enroll in Medicaid through pathways other than SSI (or SSDI/Medicare).[6] As a result, exempting Medicare and SSI beneficiaries will not avert the threat to Medicaid coverage among children and adults with significant health care needs.

For this reason, in addition to the recommendations we make below for modification of the Interim Final Rule, we also recommend that CMS use its research authority to commission studies regarding the effects of its final policy decisions, as well as state implementation choices, on health care access, coverage, and quality.

1. Despite the fact that the DRA amendment is drafted as a limitation on federal financial participation, not as a condition of eligibility, CMS has erroneously interpreted the amendment as a condition of eligibility, thereby permitting the denial of coverage, extensive enrollment delays, and wrongful coverage terminations.

The DRA, as drafted, operates as a limitation on FFP for state Medicaid programs, not as a condition of eligibility. Despite this fact, the Preamble to the Rule states that applicants "should not be made eligible until they have presented the required evidence." 71 Fed. Reg. 39216 The rule itself states that "states must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting . . . eligibility." Interim Final 42 C.F.R. 435.407(j).

Because the DRA amendment speaks to funding and not eligibility, the final rule should be revised to commence Medicaid enrollment upon applicant verification, thereby allowing coverage to begin while necessary documentation is collected and submitted. This change is critical to ensuring that eligible individuals are not turned away simply because certain documents are not readily available.

We also strongly recommend that states be required to establish reasonable time periods for documentation presentation in the case of both applicants and recipients. By CMS' own admission, the value of fraud in connection with prior self-attestation policies was so modest, particularly in relation to the health and health care impact of erroneous terminations and denials.

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[6] Centers for Health Care Strategies *The Faces of Medicaid* (Princeton N.J. 2000)

We view changes related to eligibility and submission of documents as particularly crucial, given the effects of unnecessary and burdensome eligibility documentation requirements on enrollment rates and delays. The dangers of erroneous exclusion are particularly high in this case, since the implementation time period given CMS and state agencies was startlingly short. CMS barely has supplied information to states and has undertaken no extensive, systematic outreach comparable to the implementation efforts launched around the less important Medicare Part D legislation.

2. The interim final rule fails to focus specifically on the interaction of Medicaid and SCHIP in states with separately administered SCHIP programs

Because the DRA amends only Medicaid, states that administer separate SCHIP programs should be expressly permitted to enroll children in these separate programs pending submission of necessary documentation that will establish their Medicaid eligibility status. To the extent that CMS interprets the DRA as adding a condition of eligibility to Medicaid (a decision with which we strongly disagree), then children who lack these documents in effect become "targeted low income children" within the meaning of the SCHIP statute. The use of SCHIP as an immediate source of stable coverage should be expressly recognized for all children, including "unborn children" in accordance with CMS policy regarding coverage of this sub-class of SCHIP children.

3. The interim final rule fails to exempt foster care children receiving assistance under Title IV-E of the Social Security Act

The documentation requirements are linked to individuals whose citizenship status must be verified in accordance with §1137(b) of the Social Security Act. Missing from this list are children and adolescents in Title IV-E placements. Despite this fact, the Interim Rule specifically requires that such children have both a declaration of citizenship and documentary evidence. 71 Fed. Reg. at 39216. This requirement appears to be wholly unsupported by the exemption of these children from the verification statute itself, an exemption that we believe is no "scrivener's error."

Since state child welfare agencies in fact already verify citizenship and legal status in the case of Title IV-E children, and Title IV-E is not mentioned in §1137(b)(7), we are at a complete loss to understand why CMS would not exempt these most vulnerable children from documentation requirements, just as it does in the case of Medicare and SSI recipients. Of course, regardless of the presence or absence of FFP, states of course have an obligation to ensure the health of children in their care or custody under *in loco parentis* doctrine. But at the same time, the requirement that states jump through additional hoops in order to secure the federal funding to which they are entitled appears to us to be not only unauthorized by law but gratuitous. We recommend that CMS exempt children receiving Title IV-E payments.

4. CMS fails to permit pregnancy and birth-related Medicaid claims payment records to suffice as documentation of citizenship.

Clearly the use of Medicaid claims payment records surrounding the birth of a child would satisfy documentation requirements, as would evidence of payment for prenatal care in the case of "unborn children" in the case of states whose SCHIP programs elect to recognize "unborn children" who, once born, become Medicaid eligible. The final rule should incorporate such evidence as acceptable proof.

5. CMS has been unnecessarily restrictive in establishing what constitutes acceptable documentation related to proof of identity

The DRA specifies that any identity document described in §274(A)(b)(1)(D) of the Immigration and Nationality Act constitutes satisfactory evidence of identity documentation. Yet for reasons that are unclear, the CMS interim rule fails to list all of the documents contained in the Department of Justice's final regulations regarding documents. CMS should be guided by 8 C.F.R. 324a.2 in its entirety and should accordingly revise its own more restrictive list.

6. CMS has adopted an unnecessarily restrictive approach to its affidavit policy in cases in which no documentary proof of citizenship or identity can be obtained.

The proposed rule contains an appropriate provision permitting the use of affidavits to establish citizenship but only in "rare circumstances." 42 C.F.R. §435.407. The requirements necessitate affidavits from two qualified individuals with personal knowledge of the events that establish the applicant's or recipient's claim to citizenship. This is an insurmountable barrier for potentially millions of persons, particularly children and adults whose age or mental incompetency precludes the provision of assistance to the affiant.

A crabbed approach to the use of affidavits can be expected to have two adverse impacts. First, states will be loathe to use the affidavit system, out of fear that they will not be able to prove the qualifications of the affiants in an audit. Second, even where states are willing to use affidavits, individuals may fear to provide an affidavit because of their obligation to affirmatively verify status in the case of individuals who may be known to caregivers only through a professional relationship.

The final rule should permit states to use their best judgment in determining when required proof is unobtainable and affidavits therefore will be acceptable. Furthermore, af fiants should be required only to affirm that they possess no specific knowledge that an individual lacks citizenship or legal status.

7. CMS should not require applicants and recipients to submit original or certified copies

Nowhere in the DRA is there a requirement that applicants and recipients file originals or certified copies of documentation. We recommend that this provision be eliminated from the final Rule.

8. CMS' failure to link the documentation requirements to outstationed enrollment requirements related to the initial processing of applications

States are required to maintain outstationed enrollment programs to assist with enrollment. Mandatory sites for outstationed enrollment are disproportionate share hospitals, federally qualified health centers, and rural health clinics. The rule is silent on the relationship between this requirement and the outstationing rule, which clarifies that collection of documentation is an aspect of the initial processing of applications that must be available at outstation locations. 42 C.F.R. §435.904(d)(2). Nor does the Interim rule clarify the availability of FFP to support initial processing functions at outstation locations.

The final rule should clarify that assistance with collection of citizenship documents is part of the initial processing requirements that must be in place at all outstation locations. Furthermore the rule should clarify the circumstances under which FFP not only can be available but in fact must be available. In this context, collection of documentation for verification of citizenship should be considered a direct state agency function related to the establishment of FFP entitlement, and states therefore should be required to ensure that administrative costs incurred by outstation providers and related to the operation of outstation locations are treated as state expenditures for purposes of FFP.

9. CMS has failed to establish standards and criteria to ensure implementation compliance with Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, Title VI of the 1964 Civil Rights Act, and other applicable civil rights laws

The obligation of state Medicaid programs to comply with U.S. civil rights law is a settled matter.[7] Federal regulations prohibiting discrimination on the basis of race, national origin, and disability preclude the use of methods of administration by recipients of public funds, including both public agencies and federally assisted providers, which have the effect of discriminating. The interpretation and application of this Interim Rule by both public agencies and federally assisted health care providers could have two distinct types of discriminatory effects.

The first type of discriminatory effect concerns public agency practices. State administration choices related to outreach and assistance may fail to reach minority applicants and recipients, particularly those whose primary language is not English or for whom written or oral speech is not accessible. For example, a state's selection of outreach approaches or enrollment supports may adversely affect minority individuals. Similarly, state implementation of documentation requirements, time periods to gather and submit documentation, and other matters, may fail to make the types of reasonable modifications in program administration that are required under the ADA in order to make medical assistance accessible.

The second barrier has to do with provider behavior. Providers may attempt to avoid certain patients in the belief that patients will be unable to produce documents showing their citizenship status or will unable to navigate the documentation submission rules. This concern is particularly great in the case of patients whose primary language is not English. Since Medicaid permits

[7] *Olmstead v L.C. ex. rel. Zimring* 527 U.S. 581(1999)

retroactive eligibility determinations, many providers today may be willing to furnish care and to assist patients with subsequent applications. This willingness may change for selected populations in the wake of these rules however, out of concern that needed documentation will not be available.

We therefore urge inclusion in the final rule of specific standards for assuring agency and provider compliance with all applicable civil rights laws. We also recommend additional guidance on this topic, as well as CMS demonstrations to document best practices in the field of outreach to protected classes of individuals regarding the documentation requirements.

10. CMS should undertake a major outreach campaign regarding documentation and should seek additional funding for extensive assistance to support such a campaign and sources of technical support

Conclusion

We have been impressed with the energy CMS devoted to Medicare Part D outreach. Quite frankly, although Medicare Part D is very important, it pales in relation to the Medicaid documentation statute, which has the potential to cost millions of low income, disproportionately minority individuals their entire and sole source of coverage. We therefore urge CMS to use the use utmost caution in interpreting and applying this law.

Sincerely,

Sara Rosenbaum, JD, Chair
Taylor Burke, JD, LLM, Assistant Research Professor
Ann Doucette, PhD., Senior Research Scientist
Christine Ferguson, JD, Associate Research Professor
Daniel Hawkins, Guest Lecturer at GWU and Vice President for Federal, State, and Public Policy, National Association of Community Health Centers
Julia Hidalgo, ScD, MSW, MPH, Research Professor
Laura Jacobus-Kantor, PhD., Senior Research Associate
Anthony S. Lara, MHSA, Senior Research Associate
Jacqueline Leifer, JD, Senior Partner
Jeff Levi, PhD., Associate Professor
Jean M. Lynn, RN, MPH, OCN, Director of Outreach, Cancer Expert Corps
D. Richard Mauery, Senior Research Scientist and Adjunct Instructor
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Delia Olufokunbi, PhD., Senior Research Scientist
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Lee Repasch, MA, Research Scientist
Josef Reum, PHD., Associate Dean for Administration and Finance, SPHHS
Peter Shin, PhD., MPH, Assistant Research Professor
Marsha Simon, PhD., Vice President, Jefferson Consulting Group
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INSTITUTE FOR
REPRODUCTIVE
HEALTH ACCESS

32

August 11, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship Documentation Interim Final Rule, 71 Fed.Reg. 39214 (July 12, 2006)

The Institute for Reproductive Health Access works to expand reproductive rights for all women regardless of age, race or income. For years, we have worked to ensure that low-income women have adequate health coverage and are able to access a full range of health services. Medicaid is the leading source of health coverage for low-income women in the US. Medicaid provides critical services, including routine check-ups, preventive screenings, and reproductive health care, to 19 million low-income women. As women comprise 71% of the adult beneficiary population, they are disproportionately affected by barriers to obtaining and renewing Medicaid coverage.

We are writing to comment on the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This section of the DRA became effective on July 1 and requires that U.S. citizens and nationals applying for or receiving Medicaid provide documentation of their citizenship and identity. We are deeply concerned that CMS has not acted to minimize the likelihood that U.S. citizens applying for or receiving Medicaid coverage will face delay, denial, or loss of Medicaid coverage. Our comments below highlight four critical areas that CMS should modify in the final rule.

Family planning waiver programs should be exempted from the citizenship and identity documentation requirements.

Sections 435.406 and 436.406 of the interim final rule require individuals receiving benefits under section 1115 family planning demonstrations to provide documentation of citizenship. If implemented, this rule would impede access to critical, time-sensitive and cost-effective family-planning care and would leave many low-income women without the means to avoid unintended pregnancy.

Over the past decade, 24 states have obtained federal approval under section 1115 to expand Medicaid eligibility for family planning services and supplies to individuals who otherwise would not be covered. These programs have improved access to family

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planning services and have consequently reduced the number of unintended pregnancies among the covered population. The demonstrations have resulted in significant cost-savings since family planning reduces the need for more costly services associated with pregnancy and postpartum care.

The interim final rule places a significant barrier to care for individuals seeking to enroll in these programs. The problem posed by the documentation requirements is particularly serious when it comes to accessing such a time-sensitive service as family planning. Any delay in receiving services could result in an unintended pregnancy which leads to higher medical costs. We urge CMS to allow individuals receiving benefits under section 1115 family planning demonstrations to attest to citizenship in order to comply with the statute.

A record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity.
Infants born to U.S. citizens receiving Medicaid at the time of birth are deemed to be eligible for Medicaid upon birth and to remain eligible for one year so long as the child remains a member of the woman's household and the woman remains eligible for Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule states that, in such circumstances, "citizenship and identity documentation for the child must be obtained at the next redetermination." 71 Fed. Reg. 39216. However, by paying for the birth, the state Medicaid agency has already made the determination that the child was born in a U.S. hospital and is therefore a citizen. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year bar on Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to be covered by Medicaid, an application must be filed and the citizenship documentation requirements would apply. 71 Fed. Reg. 39216. Again, by paying for the birth, the state Medicaid agency has already made the determination that the child was born in a U.S. hospital and is therefore a citizen.

Newborns will not have birth records on file with state Vital Statistics agencies. The rule provides that in such circumstances, extracts of a hospital record created near the time of birth could be used as proof of citizenship, 42 CFR 435.407(c)(1), and if this "third level" of evidence was not available, a medical clinic or physician record created near the time of birth could be used, but only in the "rarest of circumstances," 42 CFR 435.407(d)(4).

Since the rule would prevent states from granting coverage until documentation of citizenship is provided, hospitals and physicians treating newborns will be at risk for delay or denial of reimbursement for the treatment of newborns who are low-birthweight, have post-partum complications, or simply need well-baby care and who must, under the

interim final rule, meet the onerous documentation requirements. Hospitals and physicians, who cannot turn away patients, will suffer financially.

The risk to the health of newborns from delays in coverage and the potential for increased uncompensated care for providers are completely unnecessary. By paying for the birth, the state Medicaid agency has already made the determination that the child was born in a U.S. hospital. We strongly urge that CMS amend 42 CFR 435.407(a) to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

CMS should not require applicants and beneficiaries to submit original documents or certified copies.

We are concerned that the requirement that only original documents or certified copies be accepted as satisfactory evidence of citizenship adds to the burden of the new requirement on applicants, beneficiaries, and state Medicaid agencies. The DRA does not require that applicants and beneficiaries submit original documents or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this requirement to the interim final regulations at 42 CFR 435.407(h)(1). CMS also estimates that it will only take applicants and beneficiaries ten minutes and state agencies five minutes to comply with the requirement. This requirement adds to the information collection burden of the regulations and compliance will take considerably longer than CMS's estimation.

Applicants and beneficiaries will have to make unnecessary visits to state offices with original documents or certified copies. While the regulations state that applicants and beneficiaries can submit documents by mail, it is unlikely that applicants and beneficiaries will be willing to mail in original birth certificates or certified copies. Moreover, they may be unwilling or unable to mail in proof of identity such as driver's licenses or school identification cards.

Most states, including New York, do not require face-to-face interviews for children and parents applying for or renewing their Medicaid coverage. Eliminating the face-to-face interview requirement was one of a number of steps that states took to simplify their eligibility processes. Mail-in applications are also more efficient for state Medicaid agencies. Requiring original documents and certified copies to prove citizenship will make it harder for working families to enroll in Medicaid and will increase the workload of Medicaid agencies. Many applicants may not be able to pay for certified copies of documents that they have lost or misplaced. Compliance with this requirement may be especially difficult for victims of natural disasters or homeless individuals who simply do not have these documents. Agencies will face additional costs if they must mail the copies or original documents back to applicants and beneficiaries.

This unnecessary requirement goes beyond the requirements that Congress imposed in the DRA. This requirement will delay coverage while applicants wait for appointments at state Medicaid agencies. In some cases, having to visit a state office will discourage applicants from completing the application process. A visit may be particularly burdensome, if not infeasible, for women who have the additional responsibility of securing childcare and transportation.

We urge CMS to revise the requirement at 42 CFR 435.407(h)(1) so that states have the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when there is no reason to suspect that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.

U.S. citizens applying for benefits should start receiving benefits once they declare that they are citizens and meet all eligibility requirements.

Under the DRA, the new citizenship documentation requirement applies to all individuals (other than Medicare beneficiaries and, in most states, SSI beneficiaries) who apply for Medicaid. The preamble to the rule states that applicants "should not be made eligible until they have presented the required evidence." 71 Fed. Reg. at 39216. The rule itself states that states "must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid." 42 CFR 435.407(j).

Under the DRA, documentation of citizenship is not a criterion of Medicaid eligibility. Once an applicant for Medicaid declares that he or she is a citizen and meets all eligibility requirements, eligibility should be granted. There is nothing in the DRA that requires a delay in providing coverage. Yet CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates.

This year, about 10 million U.S. citizens are expected to apply for Medicaid. Under the new requirement, large numbers of eligible, low-income Americans will be denied Medicaid coverage during the application process. Some U.S. citizens who become discouraged or cannot obtain the documents they need within the time allowed by the state will never receive coverage. Furthermore, most applicants will be unaware of the new requirement since CMS has not established a specific outreach program to educate U.S. citizens. Thus, the new requirement could result in significant delays for applicants and beneficiaries who are not prepared to provide documentation and must scramble to assemble the necessary documents.

We are particularly concerned that delays in Medicaid coverage will have significant effects on the receipt of timely care and will worsen health problems for millions of low-income women. These delays could lead women to forego essential preventive services, including cervical and breast-cancer screenings. In addition, delays for pregnant women may deter early entry into prenatal care, which will put both the mother and her child at risk for complications. Women who are currently enrolled in Medicaid may experience disruptions in their care when they have to renew their coverage. Low-income, eligible women must have immediate and continuous access to Medicaid so they can obtain the care that they need.

We urge CMS to revise 42 CFR 435.407(j) to state that applicants who declare they are U.S. citizens or nationals and meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary documentation.

Conclusion

We strongly urge CMS to consider the ramifications of the interim final rule on the health of low-income women and their children. The requirements specified in this document will present substantial obstacles for low-income women who seek to enroll or renew their enrollment in Medicaid. The documentation requirements will equally impact the children of low-income women. If the documentation requirements are not amended, low-income women and children may be denied or may loss coverage for crucial health services. Thank you for your attention to our comments. If you have any questions, please feel free to contact Robert Jaffe, Executive Vice-President, at (212) 343-0114 ext. 14.

Sincerely,

Robert Jaffe

fighting hunger and poverty

August 1, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship Documentation Interim Final Rule, 71 Fed.Reg. 39214 (July 12, 2006)

Dear Sir or Madam:

I am writing to comment on the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This provision of the DRA requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity. We are concerned about the rule's potential impact on access to health care for vulnerable Americans, including families that are food insecure. We offer our recommendations for revisions to the rule that we believe will better address these families' circumstances and not exacerbate their difficulties in meeting their health needs.

I am writing on behalf of the Community FoodBank of New Jersey, the state's largest distributor of donated food to charities serving up to 537,000 low-income people in New Jersey. The Hunger in America 2006 study, which we conducted with Mathematica Policy Research, revealed that 36 % of the members of households served by our food bank are children; 12% of households we serve are homeless; 68% have incomes below the federal poverty level; 20% of households report having at least one family member in poor health; and 31% have to choose between paying for food and paying for medicine or medical care.

Our specific suggestions for revisions to the rule are as follows:

The regulations should better accommodate people for whom documents are not available or do not exist. U.S. citizens who may lack the documents listed in the interim final rule include, among others, victims of hurricanes and other natural disasters, and homeless individuals. The Secretary should use his discretion under the DRA to expand on the list of acceptable documents. Specifically, we urge the Secretary to borrow a practice from the Supplemental Security Income (SSI) Program, by which state Medicaid agencies can recognize when a person without documents is in fact a U.S. citizen.

CMS should not require applicants and beneficiaries to submit originals or certified copies. The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Revising the final rule to allow a broader

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range of options, that include, but are not limited to, original or certified copies would make it more likely that clients could easily comport with the new law and would streamline states' application processes significantly. This change would likely result in the need for fewer office visits for beneficiaries, require less staff time to meet these additional demands, and will likely lead to savings in both human productivity and actual administrative costs.

Children in foster care should not have to verify citizenship again. State child welfare agencies must verify the citizenship status of these children in the process of determining their eligibility for Title IV-E foster care payments. Those outside of the IV-E program are already under the care of the state. Requiring foster children to document citizenship again constitutes an unnecessary duplication of state agency efforts and puts these children at risk of delayed Medicaid coverage

Native Americans should be able to use a tribal enrollment card issued by a federally-recognized tribe to meet the documentation requirement. Many Native Americans were not born in a hospital and have no record of their birth except through tribal genealogy records. By not recognizing tribal enrollment cards as proof of citizenship and identity, the regulations create a barrier to participation in the Medicaid program.

In addition to revising the rule, we urge CMS to undertake public education to ensure that state agencies, eligibility workers, and clients understand that the new requirements affect only Medicaid, not the Food Stamp Program. Medicaid traditionally operates in conjunction with food stamps and other benefits programs, and the programs are frequently administered by the same workers. It is vital that CMS work with states and USDA to educate caseworkers and the public about what the rule requires regarding the Medicaid program and makes clear that the provision does not affect food stamp requirements

Thank you for considering our concerns about the interim final regulations. We hope you will take into account how revising the rule would implement the DRA without undermining crucial benefits for vulnerable people.

Sincerely,

Meara Nigro
Director of Communications
Community FoodBank of New Jersey

NASW · WEST VIRGINIA CHAPTER ...the power of social work

National Association of Social Workers

August 1, 2006

Mark B. McClellan, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IRC
PO Box 8017
Baltimore, MD 21244-8017

Dear Dr. McClellan:

Re: CMS-2257-IFC

These comments on the Interim Final Rule regarding Citizenship Documentation Requirements are submitted on behalf of NASW West Virginia Chapter, representing 750 social work professionals from throughout the State of West Virginia

1. Delay in establishing eligibility for Medicaid (§436.1004)

Individuals who apply for Medicaid and have met all of the other eligibility requirements and are cooperating and diligently working to prove their citizenship should be covered under the program. Given that obtaining the required documents may take considerable time for some people, and given that the vast majority of applicants will be citizens or lawful immigrants, delaying their coverage for this paperwork is inappropriate.

Yet while the rule permits those already on the program to remain eligible while documentation is gathered, this same rule does not apply to new applicants. There is no good reason for this distinction, and we urge that all applicants who meet other requirements be covered, and that they be given a reasonable period of time in which to complete the citizenship requirements.

2. Application of the rule to children in foster care (§435.1008)

We strongly oppose the provisions in the final rule that would apply the citizenship rule to children entering foster care. These children have already suffered at the hands of adults and to deny them access to medical care until their citizenship can be proved is unconscionable. Few will be found not to be either citizens or legal immigrants, but for some potentially lengthy period of time they will have no Medicaid coverage under this rule.

It will not be easy for states to find the necessary documentation to make these children eligible, given that their birth families may not cooperate. Moreover, states already verify citizenship of about half of the children in foster care when they determine them eligible for federal foster care payments. Yet the regulations require citizenship to be proven again.

3. Gaps in the exemptions (§435.1008)

We applaud CMS for issuing the rule that individuals on SSI or Medicare will not be subjected to these requirements. However, there are gaps in these protections. In particular, individuals on

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Social Security Disability Insurance who are in the waiting period for Medicare or disability payments should also be included within the exempt group.

In addition, other individuals have also already proved their citizenship, including TANF families and children and S-CHIP applicants and recipients who get OASDI survivor, retirement and disability auxiliary benefits from SSA, and those whose citizenship has been verified by SSA for early age 62 retirement, age 60 widows or widower OASDI beneficiaries.

All of the children and adults on a federal program where citizenship ha already been determined should be exempted from these requirements.

4. Documentation Dates (§435.407(c) & (d) and §436.407(c) and (d)–third and fourth level evidence)

There is no rationale for a requirement that certain documents are only considered valid if issued at least five years before the application for Medicaid. This is an entirely arbitrary date that may cause significant hardship, particularly if the individual is unable to secure such old records.

For those now on the program, it should be sufficient that such documents existed at the time of the DRA enactment. For new applicants, a more reasonable time frame should apply, such as two or three years.

5. Evidence of identity (§435.407(e) and §436.407(e))

CMS should cite the state mental health authority among the state agencies' data systems with which a cross match may be made. Individuals with serious mental illness are likely to be among those who have great difficulty obtaining the necessary documents due to functional issues, and, in addition, the stress of this process could trigger relapse. Therefore every effort should be made for making this process as easy as possible for such individuals. State mental health agencies and the community providers who serve this population will have medical records and other data bases that enable confirmation of identity.

6. Populations needing special assistance (§435.407(g) and §436.407(g))

The language describing persons who need special assistance is not clearly written. In place of the vague and undefined phrase "incapacity of mind" to describe the people who must be assisted, it would be more appropriate to require that states must assist individuals who, "due to a physical or mental condition" are unable to comply with the requirement to present satisfactory documentary evidence.

States should also be required, in the regulation, to assist all homeless persons with securing the necessary documents. Currently, the Preamble suggests that this is mandated, but the regulation itself makes no mention of homeless people. It will be extremely hard for someone with no fixed address, little or no income and who faces daily challenges in terms of all aspects of their lives to write off for new copies of their birth certificates. Furthermore, it is highly unlikely that these individuals will have passports.

Further requirements should also be made that states assist people who have been displaced by a natural or man-made disaster or who, because of such disasters, have lost their documentation.

In all cases where the state is assisting such individuals to obtain the documents, Medicaid

coverage should be provided so that medical care can be furnished in the meantime.

7. Time frame for collecting documents (§435.407(j) and §346.407(j))

States should be given broad flexibility to allow individuals the time necessary to collect their proof of status. Unlike other information required on the Medicaid application (or for recertification), it may take some individuals considerable time to collect these documents. If the individual is working to provide the documents, this should be sufficient.

8. Outreach

CMS as well as the states should be conducting considerable outreach on this provision. At this time, we are continually learning that not only do individuals on Medicaid have no idea they must collect such documents, but nor do many front line staff of mental health agencies. People have a right to know that this onerous requirement is now in place.

9. Presumptive eligibility groups

The proposed rule does not specifically make it clear that those who meet presumptive eligibility standards are still presumptively eligible, regardless of the status of their proof of citizenship. This should be rectified, or the presumptive eligibility categories will have little meaning.

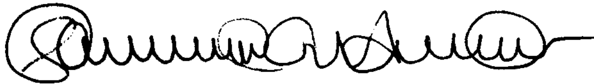
10. Rules apply across states (§435.407(h) and §436.407(h))

We applaud CMS for clarifying that this process need only be gone through once. However, it is also not completely clear that once these documents have been procured and citizenship status has been proved that this is sufficient not only for future eligibility determinations in that state, but across all states.

Finally, we also applaud CMS for clarifying that individuals need not come in person to prove their citizenship. Many states no longer require an in-person application, and requiring the individual to come in to deal with the citizenship issue would be a significant burden.

Thank you for this opportunity to comment on the proposed rule.

Sincerely,



Samuel A. Hickman, MSW, ACSW, LCSW
Executive Director

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Iron County Community Hospital
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August 15, 2006

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-8017

Re: Medicaid Citizenship Documentation
Interim Final Rules 71 FR 39214 (July 12, 2006)
FILE CODE CMS-2257-IFC

Our organization provides healthcare services to many U.S. citizens including those enrolled in our state's Medicaid program. We have reviewed the Interim Final Rules (the Rules) implementing the provisions of the Deficit Reduction Act (DRA) enacted to improve documentation of identity and citizenship for Medicaid recipients. We believe that many of the requirements included in the Rules are inconsistent with the DRA and will negatively affect health care within our state. We outline our concerns below.

1. The Rules Should Not Permit States To Delay Granting Medicaid Benefits To Qualified Applicants Who Are Making Reasonable Efforts To Gather And Submit Satisfactory Documentation of Identity and Citizenship..

Section 435.407(j) currently provides that "States must give an applicant or recipient a reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid. The time States give for submitting documentation of citizenship should be consistent with the time allowed to submit documentation to establish other facets of eligibility for which documentation is requested. (See § 435.930 and § 435.911)."1 .

Two primary problems arise from this provision: (1) It appears to permit States to delay taking action on a Medicaid application while the applicant is provided with a "reasonable opportunity" to gather documentation to demonstrate identity and citizenship; and (2) It equates the time period for gathering and submitting documentation of citizenship and identity with the time period States typically provide for gathering and submitting documentation of other, more easily obtainable, facets of eligibility.

The Rules should require States to accept a declaration in writing under penalty of perjury that the individual is a citizen or national of the United States" as provisional proof of identity and citizenship while the applicant is gathering other appropriate documentation. As CMS has previously noted, §6036 of the DRA does not change

' The citation to § 435.911 (the regulation which requires States to establish time standards for determining eligibility not to exceed 90 days for disability cases and 45 days for all other applicants) is an indication that CMS erroneously views DRA's documentation requirements for purposes of obtaining federal participation as barriers to eligibility for Medicaid. As explained herein, they are not.

eligibility for Medicaid. It merely imposes new requirements on the States for receiving FFP. In fact, 42 U.S.C. § 1137(d), which conditions eligibility for Medicaid on "a declaration in writing under penalty of perjury" that the individual "is a citizen or national of the United States," remains intact. 42 U.S.C. § 1396a continues to preclude the Secretary from approving any plan "which imposes, as a condition of eligibility for medical assistance . . . any citizenship requirement which excludes any citizen of the United States." Further, the only portion of the Medicaid Act amended by the § 6036 of the DRA deals with financial reimbursement to the States – not eligibility for benefits.

If §6036 of the DRA were interpreted as establishing new eligibility requirements for Medicaid, citizens of the United States applying for Medicaid would be treated far worse than similarly situated qualified aliens applying for Medicaid. Under 42 U.S.C. § 1137(d)(4), States may not "delay, deny, reduce or terminate" a qualified alien's eligibility for Medicaid while the individual is gathering and supplying evidence of his or her immigration status. Yet, unless the Rules are amended and clarified, it appears that States could "delay, deny, reduce or terminate" a citizen's eligibility for Medicaid while the individual is gathering and supplying evidence of his or her citizenship. Such an interpretation of the DRA would render § 6036 unconstitutional under the equal protection provisions of the Fifth Amendment.

The problem is exacerbated by the section of the Rules which equates gathering and submitting documentation of citizenship and identity with gathering and submitting documentation of other facets of eligibility. For example, in Michigan, applicants are generally allowed 10 calendar days from the date the State mails a request for verification of asset and income eligibility to collect and submit the required verifications. If the applicant is making reasonable efforts, but cannot produce the verifications within the 10 day period, the state extends the period for an additional 10 days. Generally, the documents necessary (e.g. bank statements, tax returns, pay check stubs) are either in the applicant's possession or readily obtainable by the applicant from third parties.

The same is not true for the documents the Rules require for demonstrating identity and citizenship. Based upon a recent survey of over 1,000 Michigan-based applicants, we understand that nearly 1 in 3 did not have a passport or a birth certificate and government issued pictured identification in their possession. Approximately a quarter of those individuals (7% of the total surveyed population) were born outside the State of Michigan. If the state treated its request for verification of citizenship and identity as it does other facets of eligibility, applicants born outside the State of Michigan would be expected to identify the appropriate governmental agency in the state in which he or she was born, determine the procedure and costs associated with obtaining a certified copy of the applicant's birth certificate, order the certificate, make arrangements to cover the cost, and deliver the original certificate to the State of Michigan, all within 20 days.

The problem is compounded for citizens born during periods and in areas of our country where babies were often born at home and births were not regularly recorded by any governmental agency. Under the priority scheme envisioned by the Rules, it appears that such applicants will have to obtain documentation from the out-of-state agency that no

certificate is exists and then, during the same 20 day period, obtain some alternative form of documentation. Realistically, such a feat is not possible.

While it may be possible to obtain affidavits from friends and relatives who have known the applicant for an extended period of time and could testify that to their knowledge and belief, the individual was born in a particular State and describe, in detail, the basis for that knowledge, the Rules only permit third-party affidavits in "rare" cases and then only if the affiant has personal knowledge of the applicant's citizenship. For citizens by birth, the only persons qualified to make such a statement would be persons present at the applicant's birth. Yet, the Rules require the applicant to furnish two such affidavits, at least one of which is signed by someone who is not related to the applicant. Common sense dictates that finding a midwife, physician, nurse or other individual not related to the applicant who was present at the birth will be virtually impossible if the applicant is more than 10 years old.

Obviously, if the person is reduced to obtaining census records, medical records of their birth, or other difficult to obtain documents, the standard time period for verification (10 to 20 days in Michigan) is obviously insufficient.

In the final analysis, it could take "reasonably" take months for many citizens to be able to supply the necessary documents to the state. During that period of time, if the applicant has provided the necessary declaration of identity and citizenship, and meets the eligibility requirements for Medicaid, the States should not be permitted to delay approval of the application. To permit delay or outright rejection of the application jeopardizes the health care to which citizens of the United States are entitled.

2. ***No Child Whose Birth Was Paid For By Medicaid Should Be Required To Document His or Her Citizenship.***

A child born in this county to a woman who is eligible to receive the full scope of Medicaid benefits is indisputably a citizen of this country. A child born in this country to a woman whose Medicaid benefits are restricted to labor and delivery because of her immigration status is, likewise, indisputably, a citizen of this country. 42 C.F.R. §435.407(a) or (b) should be amended to include a record of Medicaid payment for that child's birth as proof of citizenship, regardless of the immigration status of the child's mother.

3. ***All Former Beneficiaries of Medicare or SSI Should be Exempt From Documentation Requirements.***

The Rules recognize that current Medicare and most SSI beneficiaries are exempt from the documentation requirements, but do not mention former beneficiaries of Medicare or SSI. Those individuals have, likewise, already established citizenship for such programs. The fact that the person is now, for example, over the asset limit for SSI and, therefore, no longer eligible for that program, does not affect the individual's citizenship.

4. *The Priority Structure For Documentation Should Be Eliminated.*

The Rules establish an elaborate priority structure for the documents that will be deemed acceptable for verification of citizenship status which §6036 of the DRA does not require. Requiring each applicant to prove that a purported higher level of documentation does not exist wastes substantial resources, time and effort on the part of a group of individuals who by definition are unlikely to have the resources necessary to pursue alternative various forms of documentation. It also requires that each State dedicate scarce resources and staff to reviewing, recording, copying and filing multiple levels of documentation and determining whether some higher level of documentation might exist. If any benefit is gained by prioritizing documents, it is certainly outweighed by the burdens associated with determining that other levels of documentation do not exist.

5. *The Rules Associated With Demonstrating Citizenship By Affidavit Should Be Revised.*

As previously noted, the documentation by affidavit is simply unworkable for persons who are citizens by birth and cannot provide other levels of documentation. 42 C.F.R. §435.407 should be amended to permit States to consider the reasons why documentation is not available and accept affidavits from other reasonably reliable sources attesting to their knowledge of the identity of the person and his or her citizenship. For example, an affidavit from a child of an applicant who is aware of family history should be sufficient for establishing citizenship. As stated, the Rule will preclude benefits for United States citizens – not because the applicant failed to cooperate but merely because the applicant was simply unable to succeed in obtaining documents the Rule requires.

6. *The States Should Be Required To Assist Individuals To Secure Satisfactory Documentary Evidence of Citizenship And Identity Regardless of Whether The Person is Incapacitated or Has A Representative To Assist.*

Under § 435.407(g), the Rules require the States to assist certain applicants in obtaining the necessary documents, but only if the individual is incapacitated and does not have a representative to assist. Yet, the Rules require applicants to submit documentation that the States are uniquely qualified to obtain. For example, for all residents born within the State's borders, the State would be in the best position to find birth certificates and government issued identification cards. Yet, while the Rules encourage States to use data matches with their vital statistics, the Rules do not require data matches.

Moreover, the States are far more capable of making reciprocal arrangements with other States to exchange birth information for residents born outside their borders than are individual Medicaid applicants and their representatives. In fact, in a number of States (including Michigan), authorized representatives who are not licensed attorneys cannot obtain birth certificates on behalf of a Medicaid applicant.[2]

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[2] At the very least, States should be required to permit authorized representatives to obtain birth certificates on behalf of Medicaid applicants, regardless of whether the representative is a licensed attorney.

Placing the burden on Medicaid applicants - persons who are within the segment of our society who are least likely to be able to comply - defeats the purpose of Medicaid in the first instance.

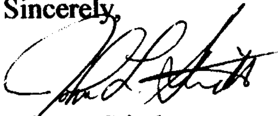
7. Originals Or Certified Copies of Documents Should Not Be Required.

Section 435.407(h)(i) specifies that only originals or certified copies of qualifying documents may be accepted to verify citizenship or identity. The result is that each individual will be either required to submit original or certified documents through the mail or present the documents in person to a state worker. If they are mailed, the States will be forced to return them to the applicant and a flood of documents subject to identity theft will be floating around our country. If they are presented in person, the State will be required to hire substantial additional staff to meet individually with each applicant, likely on more than one occasion, while the individual presents the evidence of citizenship and identity (or lack thereof) in priority order. Any benefit gained by requiring original or certified documents is far outweighed by the cost and burden of presenting such documents to the State and by keeping a record that such documents were submitted sufficient for audit purposes.

We trust our comments are helpful to you in your deliberations and that you share our concerns that, in an effort to eliminate fraudulent use of Medicaid, the current Rules establish a bureaucratic maze so dense that the benefits for one of the most vulnerable segments of United States citizenry may be lost. The loss of those health care benefits is likely to increase the need emergency care and admissions to our facilities. Providing health care to this vulnerable group of fellow citizens through emergency procedures will, necessarily, increase the cost of health care for all U.S. citizens, while simultaneously decreasing the quality of care to those who would otherwise receive Medicaid benefits.

We look forward to revised rules that address the concerns outlined above.

Sincerely,



John L. Stindt,

President/CEO

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August 9, 2006

Mark B. McClellan, M.D., Ph.D
Centers for Medicare & Medicaid Services
Department of Health & Human Services
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Mail Stop C4-26-05
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RE: Medicaid Citizenship Documentation Provisions of the Interim Final Rule with Comment Period, Regulatory Impact Statement 71 Federal Register 39214 (July 12, 2006); File Code CMS-2257-IFC

Dear Dr. McClellan:

The Alabama Medicaid Agency (AMA) is commenting on the interim final rule that was published on July 12, 2006, in the *Federal Register* (71 FR 39214) by the Centers for Medicare and Medicaid Services (CMS).

The agency appreciates the opportunity to comment on this provision of the Deficit Reduction Act of 2005 (DRA). We are hopeful that input from the states will persuade CMS to modify and clarify its guidance in order to minimize the burden on both states and current and potential Medicaid beneficiaries while still fulfilling the intent of the law.

AMA strongly encourages CMS to exempt foster care children, independent living children, subsidized adoption Medicaid beneficiaries, and individuals receiving Social Security Disability Income (SSDI) from this requirement. In addition, AMA recommends that CMS remove the "tiered" approach to the acceptable documents list, amend the types of documents currently accepted, and address the resource burden this mandate imposes on states.

We are appreciative of your recognition of the "scrivener's error" which allows Supplemental Security Income (SSI) and Medicare beneficiaries to be exempt from both the citizenship and identity requirements. CMS should, and in our opinion, has the authority to be more inclusive of other populations like those listed above in your exemption.

With regard to identity, most children in foster care simply do not have access to the documents outlined in the interim final rule. Given the contentious nature of the removal of a child, it is unlikely that the parent(s) will be available, willing, or able to provide the necessary identification documents to the state. Therefore, AMA strongly recommends that this population be exempt from these requirements. Children in state and federal adoption subsidy agreements tend to be children who were initially receiving Medicaid via foster care placement and should be exempted for the same reasons.

The application process and documentation requirements for SSI are identical to that for Social Security Disability Income (SSDI). As such, SSDI beneficiaries should be treated similarly and therefore be exempt from the requirement to document citizenship and identity.

The state of Alabama is disappointed with the narrow range of acceptable documentation and the restrictive nature CMS has imposed in regard to citizenship and identity. Many of the documents are unavailable or inaccessible for Medicaid beneficiaries. As a result, the tiered process that has been proposed appears to be a flawed model, with the primary level documents, deemed most "reliable," actually being the ones states will least likely be able to rely upon since they are the most unavailable to the average Medicaid beneficiary. We request that the documentation requirements include a wider range of documents to include documents most likely to be available to Medicaid beneficiaries.

CMS should remove the requirement for original or certified copies of documents, since this requirement was not in the original legislation. This requirement inconveniences both the client and the Medicaid agency. It places an additional financial burden on the client when they have to pay for certified documents, especially if they have a large household. A Medicaid for Low Income Family may pay more for certified copies of birth certificates for its family members than the family makes in income sources in one month. States are scrambling to administer this requirement when they have eliminated face to face interviews and established centralized or district eligibility offices which may not be within the beneficiary's county of residence. In Alabama, in some instances beneficiaries are mailing original documents including their driver's licenses, and the agency is incurring the cost of returning the documents to the beneficiary by certified mail to insure the receipt of the documents. Copies of documents that were already in the beneficiary's records prior to the enactment of this statute should be allowed. Many of the case files have these documents in them already.

We also recommend that CMS remove the restriction that certain documents (medical records, nursing home admission papers, physician statements, etc.) be created five years before the Medicaid application date. We are at a loss as to how the creation date of the document would impact the document's credibility or validity for documentation of citizenship or identity. Since we have many Medicaid beneficiaries who have been enrolled for many years, it would be difficult to find documents that pre-date their original Medicaid application date. This restriction is impractical for Medicaid beneficiaries.

CMS should allow a "preponderance of evidence" rather than the tiered approach for both citizenship and identity. This should be allowable in situations where exhaustive research has been done and all evidence points to citizenship but none of the allowable documents exist. Several documents which point to citizenship but are not listed in the guidance are at least as accurate if not more accurate than an affidavit.

The affidavit process, as defined in the interim final regulations, is overly restrictive and complicated. We recommend the Medicaid application itself be utilized to meet the requirement of the "affidavit" when the applicant attests to the identity of family members under penalty of perjury. Guardians and/or legal representatives should be allowed to complete the affidavit in the absence of the parents. Non-citizen parents should be able to attest to the citizenship of their children. Adults should be able to verify identity through affidavits as well as children. In addition, there are situations in which affidavits would be our only source of documenting both citizenship and identity for an individual. It should be allowable for both in the case of special populations, such as those who are mentally or physically impaired, homeless individuals, or those who have been displaced due to a natural disaster such as what has recently occurred with hurricanes Katrina and Rita. The Alabama Medicaid Agency will have to contend with trying to assist such individuals with compliance when documentary evidence does not exist.

In accordance with the Social Security Act §1902, §1903(v), and 42 U.S.C. §1396(e), an infant born to a non-citizen pregnant mother whose labor and delivery are covered by Medicaid is born to a woman eligible for and receiving medical assistance (emergency services) under a State plan. Therefore, we recommend that these infants be deemed eligible for Medicaid for a period of one year. It's indisputable that the child was born in the United States and is therefore a legal citizen.

Specifically, we request that CMS allow states to accept the following documents for citizenship:

- Delayed Birth Certificates Issued by Vital Statistics Agencies: Birth Certificates should not be limited to those received before age five, or those that are amended. Many adults did not have their birth certificate issued until they needed one as an adult. It was only recently that issuing birth certificates became routine at the time of birth rather than when needed for legal or other purposes. In the State of Alabama, an amended birth certificate is one where the original data was changed. A birth certificate issued more than five years after the birth is called a "delayed" birth certificate. This delayed birth certificate is issued by the Vital Statistics agency. The final regulations should allow any certified birth certificate issued by a state or territory of the US, or at the least include "delayed birth certificate" as an acceptable documentation of citizenship.
- Copies of birth records, or souvenir birth certificates, submitted by hospitals to States' Vital Records Bureau for registering births: Normally in the hospitals, the person who prepares the "souvenir" birth certificate is the same individual who reports the very same information registered on the "souvenir" document to the Vital Statistics Agency. In

Alabama, footprints are included on the "souvenir" birth certificate, making the document even more authentic.

- States' Medicaid paid claim for births: The state of Alabama establishes a unique number for the unborn child before it is born, along with the Mother's last name and first initial, and that number is linked to the mother's Medicaid record. Therefore, when the claim is paid it can easily be identified with the appropriate child.

- A religious record, showing a U.S. place of birth and either a date of birth or the individual's age when the record was made.

- An early school record for the applicant showing a U.S. place of birth, the date of admission to school, the date of birth, or the age of the individual at the time the record was made, and the names and places of birth for the applicant's parents.

For purposes of identity, we request that the following additional items be allowed:

- Birth certificates: These certificates specifically identify all necessary information that other identity documents contain.

- Voter registration cards: These are government issued cards that meet the necessary requirements to reliably prove identity.

- A child's removal court order and court documents for individuals of any age

- Immunization records: These records contain identifying information, specifically for children. States have found that parents are more likely to retain immunization records than any other types of documentation.

- Private agency identification cards for children such as Alpha Card, IDent-A-Kid and Life Touch Smile Safe Kids, when they are provided or sponsored through the school for their enrolled children.

- Photos in school yearbooks should be permitted as they identify children under 19 who are enrolled in school.

- School records for children under 19

- Affidavits: These should be permitted to prove identity for individuals of all ages.

- Religious Records which contain identifying information

- Medical records which contain identifying information

There is not a way to create an exhaustive list of reliable documents which will be available in every state. The regulations should allow any form of identity that a state has determined to be reliable and is sanctioned by law, law enforcement, or the state Attorney General's office.

AMA requests that CMS clarify that an inter-agency data match is sufficient and no additional documentation is necessary. Specifically, CMS should permit, as sufficient proof, an intra-state data match with the Department of Motor Vehicles and/or vital statistics offices. Also, in light of the fact that many states are moving to paperless case files, CMS should accept an indicator on an electronic case file rather than require states to keep "paper" case files or store images of documents in the case file or database. This indicator may be retained longer than three years if states have the capability and still be allowed as documentation of citizenship/identity when a beneficiary goes off the program for three or more years and returns as an applicant. As discussed previously, Medicaid should be allowed to match our own Medicaid paid claims data to identify citizenship for those that were born in the US and their birth was paid by Medicaid. CMS should assist the states in receiving access to SSA's NUMIDENT data for citizenship documentation.

States should be permitted to provide eligibility to individuals who declare they are citizens during the reasonable opportunity period while they obtain the citizenship/identity documentation, if they are found to be otherwise eligible. This is consistent with the process of allowing eligibility to aliens who are otherwise eligible in accordance with 42 U.S.C. §1320b-7(d)(4)(A), Further, we request that states be eligible to receive Federal Financial Participation (FFP) for providing services to such individuals during this time period.

Alabama is concerned with the treatment of inter-state transfers in the interim final rule. Frequently, the Medicaid population moves from state to state. We recommend that if one state has verified the citizenship and identity of a Medicaid beneficiary, then that documentation should be acceptable in all states without holding the transfer states liable for federal penalty for failure to document citizenship a second time. Additionally, states should be allowed to utilize private resources (companies such as TransUnion, Experian, Bridger Insight, ChoicePoint, VeriSign, etc.) which match citizenship and identity throughout the nation, applying the same technology used for credit checks, fraud and identity theft. These resources have proven useful to law enforcement and are seen as reliable. States should be able to match with these agencies and accept their validation of citizenship and/or identity, without requesting a copy of a document or image of a document from the client.

The administrative burden being imposed on the states is significantly greater than reported in this Regulation. The new rule has placed a financial strain on the Medicaid Agency due to the costs involved in system changes, data matching, training of staff, outreach and education to beneficiaries and providers, and printing of documents and letters. The rule has significantly delayed the processing of Medicaid applications and reviews. Other State Agencies such as the Department of Motor Vehicles and the Vital Statistics Agency are unable to handle the influx of beneficiaries as a result of the increased need for these documents and are also asking for relief.

Alarmed and frustrated beneficiaries are venting their frustrations and in some cases threatening our already overburdened case workers.

Alabama Medicaid is working hard to maintain compliance of the new provision. It is critical that CMS give prudent consideration to our recommendations which would provide relief to the state while maintaining the integrity of the documentation requirements of the legislation. In Alabama alone and in only one full review period for July, several hundred children and their parents/caregivers cannot produce the documentation CMS has deemed acceptable. If CMS fails to adjust the narrowly defined and restrictive requirements we will be required to terminate children who are most certainly citizens.

Sincerely,

Carol A. Herrmann-Steckel, MPH
Commissioner

CAHS/gf
cc: Renard Murray

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Northwest Health Law Advocates

August 7, 2006

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Medicaid Citizenship Documentation
Interim Final Rule, 71 FR 39214
(July 12, 2006)

Dear Secretary Leavitt:

Northwest Health Law Advocates is a public interest organization working to increase and improve access to quality health care on behalf of limited income people by providing legal analysis and representation, information, education and policy advocacy. NoHLA provides specialized assistance on consumer health care matters to attorneys, community-based organizations and policy makers, particularly in Washington State. We are writing to comment on the Interim Final Rule on Citizenship Documentation, which was published in the Federal Register on July 12, and implements § 6036 of the Deficit Reduction Act of 2005 (DRA).

We believe that the Rule as published contains some significant steps forward that will reduce the harm to beneficiaries and the burden on state Medicaid agencies that would have ensued had CMS merely incorporated its earlier SMDL # 06-012 into the Rule. Chief among the improvements is the exclusion from the documentation requirements of all Medicare beneficiaries and most of those receiving SSI. As CMS recognized, this was clearly the intent of Congress, and now many millions will be spared the hardship of attempting to clear the hurdles to Medicaid coverage created by the Rule. Welcome also is the clarification that states can use the SDX system to verify citizenship for those SSI recipients not subject to the exemption, although verification of identity for many in this population will remain an issue. Allowing states to do a vital records match in lieu of requiring a birth certificate to establish citizenship, and to consult federal or state governmental, public assistance, law enforcement or correction agency's data systems to establish identity are also both important improvements over the earlier CMS guidance in this area. Finally, we are pleased with the clarification that presumptive eligibility remains for children, pregnant women and women with breast and cervical cancer

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during the presumptive eligibility period regardless of whether they have documented their citizenship.

Unfortunately, although better than previous guidance from CMS, the Rule does not do enough to insure that people who are indeed citizens, and with regard to whom there is no credible doubt as to their citizenship, will nonetheless not receive Medicaid because they are unable to complete the scavenger hunt required by the Rule. Many of the more onerous requirements of the Rule are ill-advised and not mandated by § 6036 of the DRA, while others simply violate the Medicaid Act as amended by that section.

We discuss ten of these provisions below. The first four comments concern when and to whom the documentation requirements may or should properly apply. The remaining six address the types of acceptable documentation and the nature of the process surrounding its acquisition.

Provisions of the Interim Final Rule with Comment Period

1. **CHILDREN RECEIVING FOSTER CARE BENEFITS UNDER TITLE IV-E OF THE SOCIAL SECURITY ACT CANNOT BE, AND IN ANY EVENT SHOULD NOT BE, REQUIRED TO DOCUMENT THEIR CITIZENSHIP UNDER § 6036 OF THE DRA.**

Congress was explicit in directing to whom the new documentation requirements would apply. It did not impose those requirements on all Medicaid recipients, but rather only on an individual who:

> declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title [*i.e.*, Medicaid] . . .. 42 U.S.C. § 1396b(i)(22)

Children receiving foster care benefits under Title IV-E are simply not covered by the above language and therefore may not be subjected to the citizenship documentation requirements. Foster children do not declare under § 1137(d)(1)(A) of the SSA to be citizens or nationals of the United States for the purpose of getting Medicaid. Indeed, that section of the SSA does not require that they file any declaration at all in order to receive Title IV-E foster care benefits, for Title IV –E is not a program to which the declaration process applies. See § 1137(b) [42 U.S.C. § 1320b-7(b)]. When such children do demonstrate their citizenship (or have it demonstrated on their behalf), they do so for the purpose of getting foster care benefits. They then get Medicaid because they have been found to qualify for foster care, not because they independently meet all of the other Medicaid eligibility requirements. For example, if a state had an asset limit for foster care services that was higher than its asset limit for Medicaid, foster care children not meeting the lower Medicaid asset limit would nonetheless still receive Medicaid. Consequently, because foster children never declare to be citizens under 1137(d)(1)(A), they do not fall within the ambit 42 U.S.C. § 1396b(i)(22) and may not legally be subjected to its documentation requirements.

Even if it were permissible for CMS to apply the documentation requirements to these foster care children, it need not, and therefore should not, do so. As recognized in the preamble to the Rule, CMS has statutory authority under 42 U.S.C. § 1396b(x)(2)(C) to exclude from the

documentation requirements groups other than those listed by Congress. It is our understanding that children are in fact required to demonstrate their U.S. citizenship or nationality in the process of qualifying for Title IV-E benefits. In this regard, therefore, they are indistinguishable from SSI beneficiaries and it makes no sense to treat them differently. Knowledge that Medicaid will be available to meet the medical needs of the children they are agreeing to care for is undoubtedly a major factor in a would-be foster parent's decision regarding participation in that program. Constructing gratuitous barriers to children receiving IV-E coverage when the DRA does not require that result is terrible public policy. It will certainly deprive already imperiled children of necessary medical care, and will predictably reduce the number of families willing to participate in the foster care system at all. As a result, many children whose very lives are at risk will lose not only the opportunity for a healthy childhood, but also the chance at a safe one.

CMS should amend 42 C.F.R. § 435.1008 to include children receiving benefits under Title IV-E of the SSA as a population that is exempt from the requirement that states have documentation of their U.S. citizenship or nationality on file in order to receive federal financial participation (FFP) for medical assistance provided to them.

2. MEDICAID BENEFITS MUST BE PROVIDED TO APPLICANTS WHO HAVE DECLARED THEIR CITIZENSHIP UNDER § 1137(d)(1)(A) WHILE THEY ATTEMPT TO ACQUIRE ANY REQUESTED DOCUMENTATION.

As CMS has repeatedly recognized in the course of considering the guidance and now the regulations appropriate to implement the DRA, § 6036 of that act did not impose a new eligibility requirement on applicants for or beneficiaries of Medicaid. Rather, it imposed a new condition on the states for receipt of FFP. The eligibility requirement for Medicaid remains the declaration of citizenship or qualified alien status called for by § 1137(d) of the SSA, a section that is specifically referenced by § 6036.

With the addition of 42 U.S.C. § 1396b(x), Congress equalized the process under § 1137(d) for verifying U.S. citizenship and qualified alien status. Previously, although both groups had to file a sworn statement regarding their status in order to qualify for Medicaid, § 1137(d)(1)(A), only qualified aliens then had to provide documentary evidence to support their claimed status. § 1137(d)(2). Now, citizens too have to provide such evidence.

The Rule as written, however, would convert the provision of documentary evidence of citizenship into an eligibility requirement for citizen Medicaid applicants, as it prohibits states from providing medical assistance to a person before (s)he has presented that evidence. This approach is not legally permissible.

First, it ignores the plain language of § 1137(d)(1)(A), specifically referenced by § 6036 of the DRA, which makes the "condition of eligibility" for Medicaid "a declaration in writing, under penalty of perjury" that the individual "is a citizen or national of the United States . . .." Nothing in § 6036 purports to change this eligibility requirement, as all the amendments to the Medicaid Act in that section are made to 42 U.S.C. § 1396b, which deals with financial reimbursement to the states, not individual eligibility for benefits. Indeed, 42 U.S.C. § 1396a, which does deal with individual eligibility, continues to provide that in § 1396a(b) that:

> The Secretary . . . shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan – . . . (3) any citizenship requirement which excludes any citizen of the United States.

The Rule as proposed ignores all of this statutory language and makes the provision of evidence of citizenship an eligibility requirement for receiving Medicaid.

In addition, the Rule unconstitutionally deprives citizen applicants for Medicaid of the equal protection of the law. If the Rule were to stand as currently written, an applicant for Medicaid who claims qualified alien status will get Medicaid benefits during the reasonable opportunity period available to acquire verification of qualified alien status. This is required by § 1137(d)(4), which provides in relevant part that:

> (A) the State – (i) shall provide a reasonable opportunity to submit . . . evidence indicating satisfactory immigration status, and (ii) may not delay, deny, reduce or terminate the individual's eligibility for benefits under the program on the basis of . . . immigration status until such reasonable opportunity has been provided;

If, on the other hand, an applicant for Medicaid claims to be a U.S. citizen or national rather than a qualified alien, (s)he will not get Medicaid benefits during the reasonable opportunity period available to acquire verification of citizenship. This irrational result certainly is not required by § 6036 of the DRA. Indeed, the cross-reference to § 1137(d) in § 6036 strongly suggests that Congress intended that citizens now be treated under that section as qualified aliens always have been, perhaps no longer better, but certainly not worse. But, as it stands in the proposed Rule, citizen applicants are indeed irrationally treated worse than qualified alien applicants. The statute does not require this result and the equal protection component of the Fifth Amendment of the U.S. Constitution does not allow it.

CMS should, by amending 42 C.F.R. § 435.407(j) or otherwise, clarify that applicants for Medicaid who declare they are citizens or nationals of the United States must, if otherwise eligible, be given Medicaid benefits during the reasonable opportunity period they have to acquire evidence of their status.

3. MEDICAID BENEFITS MUST BE PROVIDED TO CITIZEN INFANTS BORN TO UNQUALIFIED IMMIGRANT PARENTS ON THE SAME BASIS AS THEY ARE PROVIDED TO OTHER CITIZEN INFANTS.

The Rule contains another distinction that is every bit as arbitrary, and therefore illegal, as the one discussed in Comment 2 above. The Rule correctly recognizes that children born in this country to women who receive full scope Medicaid should themselves receive Medicaid without the need to document their citizenship, at least until their first birthdays. However, the same treatment is not afforded to children born in this country to women who are also Medicaid recipients, but whose benefits, because of their immigration status, are limited in scope to labor and delivery. This is a purely arbitrary distinction that focuses on the wrong person. The Medicaid eligibility in question is that of the child, not the parent. As to the children, there is

absolutely no meaningful, or legal, distinction between the children that CMS proposes to cover from birth and those that it does not. A child in either situation is by definition a U.S. citizen, a fact indisputably known to the Medicaid agency because it will have paid for the child's birth in a U.S. hospital. CMS should instruct states not only that they may, but that they must, accept a record of Medicaid (or other insurance) payment for a birth in a U.S. hospital as sufficient proof of citizenship. Any other approach with regard to any child is so arbitrary as to be a violation of the due process component of the Fifth Amendment. And a different approach that is applied only to some children and not to others, when all are demonstrably citizens simply by the known fact of their birth, also violates the equal protection component of the Fifth Amendment.

CMS should amend 42 C.F.R. § 435.407(a) or (b) to include a record of Medicaid payment for a child's birth as acceptable evidence of that child's citizenship, regardless of the immigration status of the child's mother. It should also clarify that no child whose birth was paid for by Medicaid needs to document his or her citizenship for at least the first year.

4. EXEMPTION FROM THE DOCUMENTATION REQUIREMENTS SHOULD BE EXTENDED TO ADDITIONAL GROUPS.

As mentioned previously, it is a very positive development that the Rule now exempts Medicare and most SSI beneficiaries from the documentation requirements. Using its authority under 42 U.S.C. §1396b(x)(2)(C), CMS should also exempt certain other categories of Medicaid recipients and applicants who have already established their citizenship for other government benefit programs. The most obvious group in this category is comprise of *former* beneficiaries of Medicare or SSI, *i.e.,* people who have been on either of those programs in the past (at least since 1996 and perhaps from some earlier date) but who no longer are for whatever reason. It is the fact of having already established citizenship that is the basis for exempting current Medicare and SSI recipients. That fact does not change simply because a person is now, for example, over the asset limit for SSI and therefore no longer eligible for that program. CMS should therefore clarify that proof of previous receipt of Medicare or SSI will also exempt a person from the citizenship documentation requirements.

Another category that should be exempted from the documentation requirements is people who have been found eligible for Social Security Disability payments, but are still in their two-year waiting period for the receipt of Medicare. Such people are in all meaningful ways indistinguishable from those that the Rule exempts, so extending the exemption to them is only fair. In addition, CMS should exempt Medicaid applicants and beneficiaries who also receive or have in the past received TANF or SCHIP benefits, as such people have already established their citizenship in the context of those programs. Indeed, in many states, TANF recipients do not fill out a separate Medicaid application, but get medical assistance due to their receipt of TANF. These TANF recipients are therefore in much the same position as the foster children discussed in Comment 1 above. They do declare their citizenship, as they are required to do by § 1137(b) (which distinguishes them from foster children), but they do so for the purpose of getting TANF, not Medicaid.

CMS should amend 42 C.F.R. § 435.1008 to include the groups discussed in this Comment as populations that are exempt from the requirement that states have documentation of their U.S.

citizenship or nationality on file in order to receive federal financial participation (FFP) for medical assistance provided to them.

5. CMS SHOULD AMEND THE RULE TO CREATE A MEANINGFUL OUTREACH PROGRAM AS REQUIRED BY § 6036(C) OF THE DRA.

The Rule does not describe or otherwise address any "outreach program" designed to inform and assist those affected by the new documentation requirements. The failure to have developed such a program ignores the mandate of § 6036(c) of the DRA, but more importantly it has left beneficiaries and states alike in the dark as to what is mandated, permissible or prohibited with regard to helping beneficiaries comply with these new provisions. CMS should develop an outreach program that is truly designed to reach out, *i.e.,* to assist those whose eligibility might otherwise be frustrated by the new rules. As part of that effort, it should amend the proposed Rule to eliminate those policies, some of which are discussed below, that are likely to have exactly the opposite impact.

As CMS has recognized, the documentation provisions of § 6036 are directed to the states' ability to get FFP for the Medicaid services they provide. If read as written by Congress, it is the states' FFP, not an individual's eligibility, that is at stake if the evidence of citizenship is not produced. As such, it is the states that have the greatest stake in seeing that the evidence of citizenship is acquired, and if they deem it advisable to do so, they should be able to pay to acquire a qualifying document. But the Rule states that beneficiaries are responsible for the cost of qualifying documents, and it is our understanding that CMS has informed the states that the federal government will not reimburse them if they pay for the required evidence. This position is wrong both as a matter of law and policy. As discussed above, 42 U.S.C. § 1396b(x) merely requires that Medicaid applicants declaring to be citizens or nationals of the United States under § 1137(d) provide evidence of their claimed immigration status in the same way that qualified aliens have always been required to do. The Medicaid Act specifically addresses the situation in which a state expends money implementing or operating the immigration status verification system described in § 1137(d). 42 U.S.C. § 1396b(a)(4). That provision provides for 100% federal reimbursement for such costs, and the Rule should therefore be amended to inform states that: a) they may pay for citizenship and identity documents necessary to meet their obligations under § 6036 of the DRA, b) payment may be without requiring a showing of a "good faith effort" by the applicant, and c) the cost of acquiring those documents will be fully reimbursed by the federal government. This approach is not only consistent with the language of § 1396b(a)(4), it gives meaning to the "outreach plan" mandated in § 6036(c). There is simply nothing in § 6036 to suggest that Congress intended to deny Medicaid benefits to people who are able to identify documents that verify their citizenship status but simply lack the resources to pay for those documents. Indeed, the contrary is true. By amending § 1396b and not § 1396a, by cross-referencing § 1137(d) of the SSA but not amending § 1396b(a)(4), and by mandating in § 6036(c) of the DRA that CMS create an "outreach program", not a series of rules that will have the inexorable effect of denying Medicaid to eligible people, Congress clearly contemplated an implementation scheme far more balanced than the one reflected in this Rule.

This of course makes perfect sense, since Congress knows, as does CMS, that Medicaid is a means tested program and that its beneficiaries by definition do not have disposable income. Forcing applicants and beneficiaries to pay for evidence of their immigration status thus essentially imposes an application fee for Medicaid. Had Congress intended such a fee, it would

have put it, or at least the documentation requirement, in § 1396a, not in the part of the Medicaid Act that deals with reimbursement for state expenses. Therefore, both as a matter of law and good policy, CMS should clarify that states may pay for any necessary evidence that may be identified and that the federal government will, pursuant to 42 U.S.C. § 1396b(a)(4), fully reimburse the states for any such costs.

Outreach also needs to be expanded and improved with regard to "special populations." As written, § 435.407(g) neither provides sufficient guidance regarding a state's responsibilities nor casts a net wide enough to capture all those who will need assistance. As recipients of federal funds, state Medicaid agencies have a responsibility under both § 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act to provide sufficient assistance to people with disabilities to afford them the same opportunity to benefit from Medicaid as is available to people without disabilities. This responsibility to assist cannot legally just be shifted to a "representative", as the Rule currently suggests. At a minimum, CMS should clarify the circumstances under which the Medicaid agency will be responsible for providing assistance for people with disabilities. It would also be useful to provide examples of the scope of assistance that might be necessary for this population.

In addition, CMS should expand the list of reasons why a person may require special assistance to include, for example, people who are limited English proficient (LEP), and everyone who is homeless or who has been displaced by a natural disaster, such as a hurricane or a fire. Finally, CMS should clarify that states can extend the reasonable opportunity period for the period that they and the applicant deem necessary to allow any applicant, but especially those deemed to be in a "special population", time to comply with the documentation provisions.

6. THE DOCUMENTATION STRUCTURE ESTABLISHED BY THE RULE IS UNNECESSARY AND WILL RESULT IN IMPROPER DELAYS AND DENIALS OF NEEDED MEDICAID BENEFITS.

The Rule establishes an elaborate priority structure for the documents that will be deemed acceptable verification of citizenship status. Neither § 6036 of the DRA nor any administrative imperative requires such a structure. Indeed, the existence of the proposed hierarchy will at a minimum cause both state Medicaid agencies and would be Medicaid beneficiaries to waste time unnecessarily seeking evidence of higher priority when perfectly adequate evidence is readily available. It is hard to discern the perceived logic behind the hierarchical approach adopted by the Rule, and CMS has offered no explanation for its chosen course. Evidence either does or does not suffice to verify citizenship, and the Rule sets forth a long, if incomplete, list of evidence that CMS has deemed ultimately to be acceptable. If evidence anywhere on that list is available to an applicant or beneficiary, that evidence should be accepted in the first instance, for whether or not a person is a citizen or national of the United States is a yes or no question. One does not become more of a citizen, or a better citizen, or a more worthy citizen by providing "better" documentation of his or her citizenship. Nor is there any justification for turning the desire for evidence of citizenship into a scavenger hunt. Especially where, as here, evidence listed at a "higher level" is likely to cost money that most Medicaid beneficiaries do not have, the Rule should not require that it be provided or even pursued when acceptable evidence is more readily available.

If CMS nonetheless retains the hierarchical approach in the final rule, then it should also retain the level three and level four documentation options. Without those options, the documentation rules will force even more eligible citizens out of the Medicaid program and thereby greatly increase the personal risk to them and the financial burden on states and municipalities that will have to provide them with uncompensated care.

The documentation regime created by the Rule is also faulty in its failure to provide a true method of last resort for people who, for reasons ranging from mental illness to natural disasters to past discrimination, simply cannot provide any of the listed documents. The closest thing to such a procedure in the Rule is the supposed ability to establish one's citizenship through the affidavit of others. But that procedure has been made so cumbersome as to be of little value. While CMS nowhere explains what appears to be its xenophobic belief that only the affidavit of a citizen can be deemed trustworthy, it nonetheless prohibits non-citizens from doing such affidavits, even under the pains and penalties of perjury. This requirement will prevent some citizens, especially children, from getting benefits to which they are entitled. If, for example, an undocumented women gives birth at home in this country, it is likely that no one attending that birth, much less two people, will be a citizen. Yet the non-citizens in attendance would be the only people in a position to truthfully attest to the child's birth in the United States. What is the possible purpose of prohibiting them from doing so? Further, even if the people doing such an affidavit are citizens, the Rule requires them to document their status as if they themselves were applying for Medicaid. This requirement is inconsistent with at least the intent, if not the letter, of the Tri-Agency Guidance issued by H.H.S.,which prohibits inquiry into, or denial of benefits to someone because of, the citizenship status of persons not applying for the benefit in question. See http://www.hhs.gov/ocr/immigration/triagency.html. It is unlikely that very many people will voluntarily subject themselves to the indignities of this Rule, and the affidavit procedure set forth in § 435.407(d)(5) therefore is unlikely to be of any appreciable value. Nonetheless, there will be innumerable situations in which a person is unable to produce any of the documents listed in the Rule, not because (s)he has failed to cooperate but merely because (s)he has failed to succeed. In such circumstances, the Rule should allow the person to explain why (s)he cannot comply and allow the state to decide if the offered reason is credible. This is a procedure available to applicants for the SSI program, and it is no less warranted, or necessary, here.

CMS should amend 42 C.F.R. § 435.407 to allow a person who cannot acquire any of the listed documents to explain why the documents cannot be acquired, and to allow a state to provide Medicaid to that person if it finds the explanation to be credible. If the person is incapacitated to such a degree that (s)he cannot provide an explanation, the person's guardian or representative should be able to provide it instead.

7. REQUIRING ORIGINALS OR CERTIFIED COPIES OF DOCUMENTS WILL INCREASE THE COSTS AND NEGATIVE ERROR RATE ASSOCIATED WITH THE DOCUMENTATION PROCESS.

The Rule, at § 435.407(h)(1), specifies that only originals or certified copies of qualifying documents may be accepted to verify citizenship or identity. Again, CMS offers no explanation for this quite extraordinary concept, and none is readily apparent. Certainly § 6036 of the DRA does not impose such an onerous and expensive requirement. Requiring originals or certified copies will certainly increase the cost of acquiring any necessary evidence, and it will almost as

certainly require people who already have documents such as birth certificates to acquire new copies that comply with this gratuitously burdensome provision. In addition, if § 435.407(h)(1) is not amended, it will effectively reinstate the requirement that people apply for Medicaid in person, for no one of even average intelligence would be willing to send a valuable original document through the mail to a large and often impersonal bureaucracy. Requiring people to appear in person to protect their documents will have an especially burdensome impact on the working poor, many of whom cannot take time off from work without jeopardizing their jobs. Finally, many people fill out Medicaid applications at hospitals, clinics or other venues where they go to seek medical care.

CMS should amend 42 C.F.R. § 435.407(h)(1) to say that states must accept standard copies of qualifying documents and must accept the documents from whomever the beneficiary has designated to deliver the documents.

8. CMS SHOULD NOT REQUIRE THAT DOCUMENTS BE DATED AT LEAST FIVE YEARS BEFORE THE ORIGINAL MEDICAID APPLICATION DATE.

A number of documents listed in 42 C.F.R. § 435.407(c) and (d) can only be accepted as proof of citizenship if they are dated at least five years before the applicant's or beneficiary's *original* application for Medicaid. Once again, CMS has offered no explanation for this extraordinarily restrictive requirement, but its existence will often work a great hardship on people, especially those who have been in a nursing home or other institution for many years. People often enter nursing homes following a stroke or other severe medical event, and are usually not on Medicaid when they are first admitted. If they then remain in the facility permanently, after the passage of years their nursing home admission papers may be the only document available that indicates their citizenship. But that document will rarely have been created five years before their original application for Medicaid. While § 435.407(d) does not currently require that nursing home admission papers be dated five years before application, we understand that CMS considers that omission a mistake that it plans to correct with the final Rule. Thus, numerous people who have been in nursing homes or other institutions for many years will have no way to retain their Medicaid coverage, despite the fact that they are clearly citizens and have a nursing home record that establishes that fact. Additionally, birth records may be amended for many legitimate reasons that have no bearing on a person's citizenship at birth. Especially in the absence of any attempted explanation by CMS of what it believes it is accomplishing with such onerous requirement, the five year requirement appears so arbitrary and capricious as to be in violation of the both the Administrative Procedures Act and the due process requirement of the Fifth Amendment.

CMS should amend 42 C.F.R. § 435.407(c) and (d) to remove any requirement that a document must have been created at least five years before a person's initial application for Medicaid in order to qualify as verification of citizenship.

9. CMS SHOULD CLARIFY THAT ONCE A PERSON HAS SUCCESSFULLY VERIFIED CITIZENSHIP IN ONE STATE (S)HE NEED NOT DO SO AGAIN IN ANOTHER STATE.

The Rule, at 42 C.F.R. § 435.407(h)(5), clearly states that documentation of citizenship and identity should be a one time event. However, what is less clear is whether a person who has already established eligibility for Medicaid in New Jersey, for example, can later get Medicaid in Pennsylvania without again providing documentation. This appears to be the intent of the Rule, but clarification is important, especially if the Rule is not amended to lessen the financial cost to applicants of compliance.

CMS should amend 42 C.F.R. § 435.407(h)(5) to clarify that a person who has verified citizenship in one state does not need to verify his or her status again upon moving to another state. In addition, CMS should establish a documentation hot line, or some other mechanism by which one state can quickly and easily verify whether an applicant for Medicaid has, subsequent to July 1, 2006, received Medicaid in another state and therefore does not again need to verify citizenship

10. CMS SHOULD SIMPLIFY THE VERIFICATION PROCESS SET FORTH IN THE RULE SO THAT THE TIME ESTIMATES FOR COMPLIANCE MIGHT ACTUALLY BE MET

CMS estimates that it will ordinarily take an applicant for or beneficiary of Medicaid ten minutes "to acquire and provide" the documentation required by this Rule. CMS further opines that it will ordinarily take a state five minutes "to obtain acceptable documentation, verify citizenship and maintain current records." These estimates are so wildly inaccurate that one is tempted to believe that they were calculated for some other proposed rule and accidentally published with this one. Even if one incorrectly assumes that the average Medicaid recipient already has an original or certified copy of a high level qualifying document, and therefore does not have to engage in the paper chase created by the Rule, the time estimate for applicant compliance is unreasonably low. Anyone who has ever attempted to submit a document at a public assistance office in a major city knows that it is not possible to accomplish that feat within ten minutes, even if one ignores travel time to the office. Given that the average Medicaid applicant will not in fact have an original or certified copy of a high level qualifying document, the time estimate of ten minutes for applicant compliance looks much more like wishful thinking than a good faith estimate.

A simple but common scenario demonstrates how absurdly wrong the applicant time estimate is likely to be. For a Medicaid applicant born in another state who does not have a certified copy of her birth certificate, the letter requesting the copy alone will almost always take more than ten minutes just to write and mail. But before that, of course, there is the time necessary to ascertain to what agency in what city the letter must be mailed. Then there is the second letter that must be sent that contains the previously unknown charge that must be paid in advance before the certified copy of the birth certificate will be mailed to the person seeking it. Then there is the time needed to go to the Medicaid office to show them the certified copy, because few sane people would put a document they had just paid for into the mail in the hope that it will arrive at the Medicaid agency, be processed and recorded correctly, and then returned to the sender. This scenario, which realistically could take no less than two hours if one does not count the delivery time for the letters in both directions, assumes that the first letter was sent to the right agency, that the agency then responded with the correct information about the cost of the birth certificate, and that the applicant was able to get the necessary money in the necessary form without difficulty. It also assumes that the copy of the birth certificate that is mailed to the

applicant is in fact certified, and in a way that is initially acceptable to the Medicaid agency. Real life suggests that not all of these activities will unfold flawlessly on the first attempt, and therefore even more time will be required. Of course, if the applicant's birth state does not respond, or does not have a copy of her birth certificate, or does not mail out certified copies, then the amount of time that may be required to comply with the Rule may be measured in days or weeks rather than minutes.

The estimate for state compliance is simply unrelated to reality. Especially given the absence of a meaningful outreach program on the part of CMS, it will almost always take a state more than five minutes just to explain to a Medicaid applicant what it is (s)he is supposed to do and what the available options are. Further, given the Rule's imposition of a hierarchy of preference on the states, a worker, even if presented with qualifying documentation, will have to ascertain that the applicant cannot acquire some higher level document, and if not, why not. There is simply no way that this will ever be accomplished in five minutes. Then, of course, one must take into account those thousands, perhaps millions, of people who fall within the category of "special populations" and will predictably need special assistance from the state. If such people on average require just an hour of the state's time, then the overall CMS time estimate for state compliance must assume that other Medicaid applicants can on average be served in about a minute each.

In short, the time estimates given in the Rule do not represent a serious effort at compliance with the Paperwork Reduction Act. CMS should either greatly simplify the documentation process so that compliance is at least possible within the preposterously short time frames suggested by the Rule, or it should provide the public with a responsible, accurate estimate. We suggest that a conservative, good faith estimate is likely to be an average of no less than one hour for applicant compliance, and an average of at least 30 minutes per person for state compliance. Given that no less than 30 million current recipients are subject to the Rule, and not counting any future applicants, a more realistic projection of the time that will be spent on implementing the DRA in the manner that this Rule requires is therefore a total of 45 million hours, which equals 1,875,500 days, over 267,800 weeks, and more than 5,150 years of beneficiary and agency time. It should be emphasized that these estimates are based on 24-hour days and seven-day weeks. Were one instead to use a forty-hour work week, the numbers would be even larger. Estimated a bit more accurately, therefore, the manner in which CMS has proposed to implement § 6036 of the DRA looks to be a colossal expenditure of time, much of which is totally unnecessary. Rather than impose such a monumental, and perhaps unprecedented burden on the states and beneficiaries alike, CMS should do away with the hierarchy contained in the Rule and otherwise simplify the documentation requirements so that the burdens imposed more nearly equate with the benefit to be gained.

We would like to thank you for the time you have taken to consider these comments and hope that you will find them helpful as you consider the best ways to improve the proposed Rule.

Sincerely,

Janet Varon
Executive Director

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August 8, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

Dear CMS:

The following comments are submitted on behalf of the Maine Association of Interdependent Neighborhoods (M.A.I.N.), a state-wide low-income advocacy organization, whose membership includes many Medicaid recipients who will be compelled to comply with the new citizenship verification rules.

We are writing to comment on the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This provision of the DRA became effective on July 1 and requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity.

We recommend the following changes to the rules to ensure that eligible Medicaid recipients are able to access the medical services that they need without facing unfair delay or denial.

1. Medicaid benefits should be provided to applicants who have declared their citizenship while giving them a reasonable opportunity to provide the necessary documentation. 42 C.F.R. § 435.407(H)(1).

We are extremely concerned about the requirement that applicants provide documentation prior to coming on the program. Under the Deficit Reduction Act, citizenship is not required for Medicaid eligibility. The DRA does not require that a state delay providing coverage before receiving the appropriate documentation for citizenship as long as the person is determined otherwise eligible for the program. Like recipients, applicants should be placed on the program and given a reasonable opportunity to collect documentation.

It will take time for applicants to collect all of the necessary documentation. Individuals born outside of Maine will need to collect birth certificates from their state of birth. The process to

secure this documentation may often take more than three months. This is too long for applicants to wait to access services. We fear that preventing applicants from being determined eligible for Medicaid until after they provide citizenship verification documentation will stop many people with health care needs from gaining access to necessary services. Some will be forced to use the emergency room for care while others will go without services.

2. The rules should allow states the flexibility to accept copies of documents to verify citizenship and identity. 42 C.F.R. § 435.407(H)(1)

We have concerns about 42 C.F.R. § 435.407(H)(1) which requires the submission of original or certified copies of documents. This rule is contrary to the policy which allows eligibility to be determined without a face to face interview. In a rural state such as Maine, the ability to apply by mail is essential. The requirement in this regulation essentially negates that policy since few, if any, will send their passports, driver's licenses and other essential documents to the state through the mail system. Even if the documents will not be misplaced, the person is without his/her driver's license when driving which is a violation of state law.

Our suggestion is that states be given latitude on whether to require originals or certified copies. It is our understanding that CMS staff has stated that even if a state accepts what the state believes to be an original, the state will be liable if the "original" turns out to be a fake documents. Therefore, since states are responsible for the validity of the document, they should be permitted to determine under what circumstances originals will be required, e.g. if there is any suspicion regarding the authenticity of the document.

We urge CMS to revise the regulation by modifying the requirement at 42 CFR 435.407(h)(1) to make it clear that a state has the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when the state has no reason to believe that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.

3. Exemption from the citizenship verification requirement should be extended to additional groups.

While we appreciate the decision to exempt both Medicare and SSI recipients[1] from this new requirement, the exemption should be expanded to cover recipients of Social Security Disability (SSD) benefits who have not yet received Medicare (i.e. SSD recipients in their first 24 months of Social Security Disability). Likewise, recipients of OASDI survivor and retirement benefits from SSA should be exempted from Medicaid proof of citizenship requirements.

Recipients of Social Security Disability are no different than the other groups exempt from this requirement except that they are subject to a 24 month waiting period for Medicare. Likewise, recipients of other SSA benefits who have proved their citizenship for SSA meet the Medicaid citizenship verification standards and therefore should be exempted.

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[1] Medicare recipients generally get their Medicare automatically with their Social Security and do not otherwise apply for Medicare.

4. Foster Care children should not be required to document their citizenship.

State child welfare agencies must verify the citizenship status of foster care children in the process of determining their eligibility for Title IV-E payments. And children who are determined eligible for Title IV-E are automatically eligible for Medicaid. Because foster children do not declare their citizenship under section 1137(d)(1)(A), they are not subject to the citizenship requirement under the DRA.

Requiring foster care children to prove their citizenship through this new requirement will lead to unnecessary duplication of state agency efforts and puts these children at risk of delayed Medicaid coverage. We urge CMS to exempt foster care children from the documentation requirement.

5. Medical records of birth should be accepted documentation for newborns. 42 C.F.R. §435.407(c)

The rules should allow the state Medicaid agency to establish citizenship, at the second level, for newborns for whom Medicaid pays the birth claims and for whom Medicaid has the infant's name. (The Medicaid claims payment record usually contains an identifier for the new born.) Since infants born in the United States are automatically citizens, there should not be a separate requirement for the newborn to later establish citizenship.

The risk to the health of newborns from delays in coverage and the potential for increased uncompensated care for providers are completely unnecessary. The state Medicaid agency has already made the determination that by paying for the birth, the child was born in a U.S. hospital.

We urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual is satisfactory documentary evidence of both identity and citizenship.

6. The rules should be clear that FFP is available for the administrative cost of helping individuals pay for documentation. 42 C.F.R. §435.1008

The rules should make clear that FFP is available to pay for documents needed to prove citizenship/identity. While we understand that CMS staff has orally stated that this is the policy, it would help to make the policy clear on this point.

7. States should be allowed to propose alternative documentation for citizenship and identity. 42 C.F.R. §435.407 (e) and (g)

The DRA gives the Secretary discretion to expand on the list of documents included in the DRA that are considered to be "proof" of citizenship and a "reliable means" of identification.

We, therefore, urge the Secretary to use this discretion to permit state Medicaid agencies to propose alternative means to otherwise determine citizenship when citizenship can not reasonably and timely be established under the one of the four levels. For example, a state may

propose to allow affidavits that don't meet the level 4 criteria, but which with other forms of proof, e.g. a voter record or additional affidavits, taken together are reliable.

The major component for proof of identity is the driver's license. However, many people, particularly poor people who live in urban areas and rely on public transportation, will not have a driver's license. They likewise will not have any of the other documents listed in this rule. The remaining option of using data system matches is helpful, but still leaves out many people. Therefore, the rule should be amended to permit states to submit to the Secretary for approval alternative means to prove identity. Lastly, the rule should be amended to permit the use of an affidavit and medical records for proof of identity for adults.

We urge the Secretary to exercise his discretion to give states flexibility to use alternative methods to verify citizenship or identity in "special circumstances," when the state finds that compliance with the regulations would be a hardship and the state has reasonable grounds to conclude that the individual is a citizen.

8. States should be allowed to provide "good cause" exemptions in limited situations.

There will undoubtedly be cases when, despite everyone's best efforts, citizenship can not be documented in compliance with the interim rules. For example, victims of hurricanes and natural disasters, whose records have been destroyed; homeless individuals; and naturalized citizens who have lost their certificate of naturalization and others may not be able to meet the new requirement.

States should be permitted to provide a limited exception based upon "good cause." CMS could monitor the number of "fifth level" good cause exceptions which are granted to determine, as with other levels, whether there is good reason for not meeting the higher priority levels.

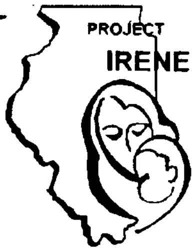
9. The rules should not require that documents be created at least five years prior to Medicaid eligibility. 42 C.F.R. § 435.407(c) & (d)

We fail to see the reasoning behind the requirement that documents must have been created at least 5 years prior to Medicaid eligibility. People don't choose to go into the hospital in order to create a record to be later used to establish citizenship. We fail to see the difference between someone who was hospitalized in 2000 and someone hospitalized in 2003. We urge the Secretary to remove any requirement that a document must have been created at least five years before a person's initial application for Medicaid in order to verify citizenship.

We appreciate the opportunity to submit these comments and for the time taken to consider these comments.

Sincerely,

Jack Comart and Ana Hicks



Project IRENE

Illinois Religious Engaging in Nonviolent Endeavors

An Activity of the Leadership Conference of Women Religious Region 8

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projectirene@aol.com

LCWR Region 8
Adrian Dominican Sisters
Benedictine Sisters of Chicago
Benedictine Sisters of the Sacred Heart
Cenacle Sisters of North America
Congregation of the Sisters of St. Agnes
Daughters of Charity of St. Vincent de Paul
Daughters of Divine Love
Dominican Sisters of Springfield, IL
Felician Sisters
Franciscan Sisters of Chicago
Franciscan Sisters of the Sacred Heart
Holy Spirit Missionary Sisters
Hospital Sisters of the Third Order of St. Francis
Institute of the Blessed Virgin Mary
Little Company of Mary
Mantellate Sisters, Servants of Mary
Marist Sisters
Missionary Sisters of St. Charles Borromeo
Missionary Sisters of the Sacred Heart of Jesus
Poor Handmaids of Jesus Christ
School Sisters of Notre Dame, Chicago Province
School Sisters of St. Francis
School Sisters of St. Francis of Christ the King
Servants of the Holy Heart of Mary
Sinsinawa Dominicans
Sisters of Charity, BVM
Sisters of Christian Charity
Sisters of Mercy, Chicago Regional Community
Sisters of Providence
Sisters of St. Benedict, Rock Island
Sisters of St. Casimir
Sisters of St. Francis of Mary Immaculate
Sisters of St. Francis of the Immaculate Conception
Sisters of St. Joseph of LaGrange
Sisters of St. Joseph, Third Order of St. Francis
Sisters of the Holy Family of Nazareth
Sisters of the Living Word
Sisters of the Resurrection
Society of Helpers
Wheaton Franciscan Sisters

August 2, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship Documentation
Interim Final Rule,
71 Fed.Reg. 39214 (July 12, 2006)

On behalf of Project IRENE, I am writing to comment on the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This provision of the DRA became effective on July 1 and requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity.

I am deeply concerned and disappointed that CMS has not acted to minimize the likelihood that U.S. citizens applying for or receiving Medicaid coverage will face delay, denial, or loss of Medicaid coverage. Our comments below highlight four areas that CMS should modify in the final rule.

1. **U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements.**

Under the DRA, documentation of citizenship is not a criterion of Medicaid eligibility. Once an applicant for Medicaid declares that she or he is a citizen and meets all eligibility requirements, eligibility should be granted. There is nothing in the DRA that requires a delay in providing coverage. Yet CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates.

1. U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements.

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This year, about 10 million U.S. citizens are expected to apply for Medicaid who are subject to this requirement. Most of these citizens are children, pregnant women and parents who will be subject to the new citizenship documentation requirement. The net effect of the prohibition on granting these individuals coverage until they provide documentation of their citizenship will be to delay Medicaid coverage for large numbers of eligible, low-income pregnant women, children and other vulnerable Americans. This is likely to delay their medical care, worsen their health problems and create financial losses for health care providers.

We urge CMS to revise 42 CFR 435.407(j) to state that applicants who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary documentation.

2. Children who are eligible for federal foster care payments should be exempt from the citizenship documentation requirement.

The interim final rule applies the DRA citizenship documentation requirements to *all* U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. The rule does not include roughly one million children in foster care, including those receiving federal foster care assistance under Title IV-E. This program already requires state child welfare agencies to follow the Department of Justice interim guidelines on verification of citizenship thus requiring unnecessary duplication of state agency efforts and placing foster care children at risk of delayed Medicaid. When Medicaid eligibility for children in foster care is delayed, foster parents may rely on emergency care or delaying doctor's visits for non-emergency care to the point that a child's condition deteriorates to the point that emergency care is needed.

We urge CMS to revise 42 CFR 435.1008 to add children eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirement.

3. A state Medicaid agency's record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity.

Among the children subject to the documentation requirements are infants born in U.S. hospitals. Under current law, infants born to U.S. citizens receiving Medicaid at the time of birth are deemed to be eligible for Medicaid upon birth and to remain eligible for one year so long as the child remains a member of the woman's household and the woman remains eligible for

Medicaid (or would remain eligible if pregnant). The preamble to the interim final rule states that, in such circumstances, "citizenship and identity documentation for the child must be obtained at the next re-determination." 71 Fed. Reg. 39216. This makes no sense, since the state Medicaid agency paid for the child's birth in a U.S. hospital and the child is by definition a citizen. The risk to the health of newborns from delays in coverage and the potential for increased uncompensated care for providers are completely unnecessary. The state Medicaid agency has already made the determination, by paying for the birth, that the child was born in a U.S. hospital.

We strongly urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

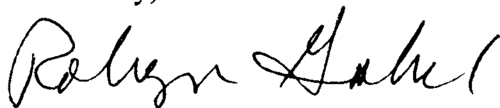
4. CMS should not require applicants and beneficiaries to submit originals or certified copies.

The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this as a requirement in the interim final regulations at 42 CFR 435.407(h)(1). This requirement adds greatly to the information collection burden of the regulations and calls into question the estimate that it will only take applicants and beneficiaries ten minutes and state agencies five minutes to comply. Requiring original or certified copies adds to the burden of the new requirement for applicants, beneficiaries, and states and makes it more likely that health care providers will experience delays in reimbursement and increased uncompensated care.

We urge CMS to revise the regulation by modifying the requirement at 42 CFR 435.407(h)(1) to make it clear that a state has the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when the state has no reason to believe that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.

The Illinois Maternal and Child Health Coalition respectfully submits these comments and urges CMS to adopt the recommended changes to the Medicaid Citizenship Documentation rule. We believe that these changes will prevent unnecessary delay of Medicaid coverage, which can jeopardize the health, and well-being of pregnant women, children and other vulnerable populations covered under Medicaid.

Sincerely,



Robyn Gabel
Executive Director

This year, about 10 million U.S. citizens are expected to apply for Medicaid who are subject to this requirement. Most of these citizens are children, pregnant women and parents who will be subject to the new citizenship documentation requirement. The net effect of the prohibition on granting these individuals coverage until they provide documentation of their citizenship will be to delay Medicaid coverage for large numbers of eligible, low-income pregnant women, children and other vulnerable Americans. This is likely to delay their medical care, worsen their health problems and create financial losses for health care providers.

On behalf of Project IRENE, I urge CMS to revise 42 CFR 435.407(j) to state that applicants who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary documentation.

2. Children who are eligible for federal foster care payments should be exempt from the citizenship documentation requirement.

The interim final rule applies the DRA citizenship documentation requirements to *all* U.S. citizen children except those eligible for Medicaid based on their receipt of SSI benefits. The rule does not include roughly one million children in foster care, including those receiving federal foster care assistance under Title IV-E. This program already requires state child welfare agencies to follow the Department of Justice interim guidelines on verification of citizenship, thus requiring unnecessary duplication of state agency efforts and placing foster care children at risk of delayed Medicaid. When Medicaid eligibility for children in foster care is delayed, foster parents may rely on emergency care or delaying doctor's visits for non-emergency care to the point that a child's condition deteriorates and emergency care is needed.

On behalf of Project IRENE, I urge CMS to revise 42 CFR 435.1008 to add children eligible for Medicaid on the basis of receiving Title IV-E payments to the list of groups exempted from the documentation requirement.

3. A state Medicaid agency's record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity.

Among the children subject to the documentation requirements are infants born in U.S. hospitals. The rule provides that in such circumstances, extracts of a hospital record created near the time of birth could be used as proof of citizenship, 42 CFR 435.407(c)(1). If not available, a medical record created near the time of birth could be used, but only in the "rarest of circumstances" 42 CFR 435.407(d)(4). However, the state Medicaid agency has already made the determination, by paying for the birth, that the child was born in a U.S. hospital and the child is by definition a citizen. The proposed rule allows for a lag time in coverage, delay or denial of reimbursement to the provider, and ultimately places the health of newborns at risk. These risks are unnecessary and can be avoided by allowing the state Medicaid agency's record of payment as satisfactory documentation.

On behalf of Project IRENE, I urge that 42 CFR 435.407(a) be amended to specify that the state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is satisfactory documentary evidence of both identity and citizenship.

4. **CMS should not require applicants and beneficiaries to submit originals or certified copies.**

The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this as a requirement in the interim final regulations at 42 CFR 435.407(h)(1). This requirement adds greatly to the information collection burden of the regulations and calls into question the estimate that it will only take applicants and beneficiaries ten minutes and state agencies five minutes to comply. Requiring original or certified copies adds to the burden of the new requirement for applicants, beneficiaries, and states and makes it more likely that health care providers will experience delays in reimbursement and increased uncompensated care.

On behalf of Project IRENE, I *urge CMS to revise the regulation by modifying the requirement at 42 CFR 435.407(h)(1) to make it clear that a state has the option of accepting copies or notarized copies of documents in lieu of original documents or copies certified by the issuing state agency. States should be able to accept copies when the state has no reason to believe that the copies are counterfeit, altered, or inconsistent with information previously supplied by the applicant or beneficiary.*

On behalf of Project IRENE, I respectfully submit these comments and urge CMS to adopt the recommended changes to the Medicaid Citizenship Documentation rule. I believe that these changes will prevent unnecessary delay of Medicaid coverage that can jeopardize the health and well-being of pregnant women, children and other vulnerable populations covered under Medicaid.

Sincerely,

Rose Mary Meyer, BVM
Director
Project IRENE

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CENTE

Board Chair
Jean S. Fraser

Members

Alameda Alliance for Health
Ingrid Lamirault
Chief Executive Officer

Contra Costa Health Plan
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Santa Clara Family Health Plan
Leona M. Butler
Chief Executive Officer

LHPC

Milton S. Camhi
Interim Chief Executive Officer

Katie M. Trueworthy
Policy Director

Mary Adams
Association Coordinator

Lobbyist

James C. Gross
Nielsen, Merksamer, Parrinello, Mueller & Naylor, LLP

August 4, 2006

The Honorable Michael O. Leavitt
Secretary of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-2257-IFC

Dear Secretary Leavitt:

The Local Health Plans of California (LHPC), representing the eight, publicly governed, not-for-profit Local Health Plans serving Medi-Cal enrollees in nine counties, is submitting this letter in response to the CMS interim final rule issued on July 6, 2006 regarding the citizenship documentation provision enacted in Section 6036 of the Deficit Reduction Act of 2005 (DRA). LHPC appreciates the opportunity to comment on the interim rule, and hopes the comments and recommendations to follow are taken into account prior to the final ruling.

LHPC provides benefits to a significant number of Medi-Cal beneficiaries enrolled in eight comprehensive Medi-Cal health plans. Our goal is to offer input that will allow for implementation in a manner that promotes uninterrupted Medi-Cal services for current beneficiaries and promotes access to services for eligibility applicants. We are deeply concerned that portions of the new document requirements unintentionally jeopardize services and undermine access to the public safety net as well as create an increased financial burden to the health care system overall.

Recommendation #1: Eliminate or simplify the tiered hierarchy approach to citizenship documentation and allow states the flexibility and discretion to implement the DRA requirements.
The interim rule lists acceptable documents required for proof of citizenship as a tiered hierarchy, including four tiers of proof of citizenship and one tier of proof of identify. Individuals are requested to submit documents at the highest level of reliability before given a "reasonable opportunity period" to submit documents in the lower tiers of reliability. The proposed hierarchy of documents is complex and creates a burden for states to implement and monitor, and a burden on beneficiaries
and applicants to both understand and comply. Obtaining documents will be most challenging for naturalized citizens or southern born African Americans, homeless, people with mental health illness, people with addictions, and people with unstable or transient housing situations. Some of our LHPC plans operate in rural areas where applicants move frequently for work and lose track of important documents.

Allowing states the flexibility to determine their documentation requirements rather than having them comply with an assigned hierarchy of acceptability documents will help to maintain access to critical medical services for those groups at greatest risk of losing coverage.

1225 Eighth Street, Suite 440 ★ Sacramento, CA 95814
Phone: (916) 448-8292 ★Fax: (916) 448-8293 ★ Email: lhpc.org

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Recommendation #2: Allow states to accept copies of all citizenship and identity documents
Requiring original documents as the only acceptable form of documentation is costly, time consuming, and creates a complex compliance process. The fact that enrollment is a mail-in process creates a significant increase in workload for application assistors having to obtain documents from government agencies or having to mail original documents back to individuals. Also, most individuals want to keep such valuable documents in their possession. Add to that the cost and complexity of obtaining an original or certified copy for this population and the result is a burdensome, costly, and impractical process for both application assistors and current and prospective beneficiaries.

Recommendation #3: Allow states to broaden the list of beneficiaries who are exempt from the DRA's citizenship documentation requirements including IV-E foster care beneficiaries and newborn infants born to women who are Medicaid beneficiaries.
We were very pleased to see in the interim regulations that seniors and people with disabilities who receive Medicare or Supplemental Security Income (SSI) are exempt from additional documentation requirements. There are two more vulnerable populations we strongly recommend also be exempt: a) Foster care beneficiaries are at particular risk of losing coverage. There is an existing link between Medicaid and foster care where state child welfare agencies already verify the citizenship of these foster youth. We recommend foster care children be exempt from proof of citizenship requirements or at a minimum, states should be allowed to match and confirm documents that exist in one of the program case files. b) Newborns born to a mother on Medicaid should be automatically enrolled via an electronic match to county vital records without having to obtain birth certificates or identity document. Federal law already mandates that these children are automatically enrolled in Medicaid.

Recommendation #4: Separate proof of citizenship from eligibility allowing beneficiaries and applicants to be enrolled while submission of documents is pending.
The interim rule requires applicants to remain ineligible for Medicaid while beneficiaries retain eligibility throughout this documentation process. Section 6036 of the DRA states that proof of citizenship requirement was not a condition of eligibility. This process could take a significant amount of time, especially with the current tiered system of documentation. As health plans, we encourage preventive care which has both health and cost benefits. From a health and fiscal stance, it is counter-productive to delay health coverage while applicants try to obtain adequate paperwork to provide citizenship and identify.

Recommendation #5: Encourage states to electronically document citizenship, as well as develop additional data matches with state and county agencies to verify citizenship.
We were pleased to see that the interim rules allow citizenship verification via state vital statistic agencies in place of a birth certificate. However, LHPC is concerned that this interim rule will not be sufficient and should also allow for future electronic capabilities. County agencies should make it a priority to access information on behalf of an applicant rather than require individuals to submit documents. States should have the flexibility to use whatever electronic/data resources are available since they are accurate and cost effective. For example, states can have the option of working with the Department of Motor Vehicles to share information since driver licenses are acceptable forms of citizenship and identity.

Recommendation #6: Allow funds to be allocated for outreach, education and application assistance related to DRA implementation. In addition, allow states, counties, and health plans to produce their own educational materials regarding this change.

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The additional burden of this new requirement will be felt among enrollees, current beneficiaries, health plans, county Medi-Cal enrollment agencies and other county agencies. Because of this, educational efforts will be important as will reimbursement for these efforts and the work done by application assistors and eligibility workers to obtain proper documentation. States and counties need the latitude to create their own educational materials to communicate best with their local communities.

Recommendation #7: Delay implementation of the DRA citizenship documentation requirements until states can set up adequate processes.
States need adequate time to implement a process that ensures a smooth transition with minimal disruption of program administration or access to coverage for eligible beneficiaries. We strongly recommend that CMS allow states to get more streamlined before implementing DRA requirements, especially in aligning data matches. For example, the interim guidelines make reference to an automated system states can use to verify citizenship and identify Medicaid recipients and applicants. It would be efficient and cost-effective to make this verification system available to states before implementing a complex system that will change dramatically with the introduction of a citizenship matching system. Another example is that the State Medicaid Directors Letter (SMDL) distributed by CMS on June 9, encourages states to educate beneficiaries and potential applicants about the changes but many issues remain unresolved. The SMDL contained no details about the outreach plan or availability of federal financial participation for state administrative costs. Delaying implementation until these details are worked out will significantly impact and benefit both Medicaid administrators and recipients.

Thank you again for the opportunity to comment on the interim final rule. LHPC's recommendations are based on a strong desire to ensure implementation does not create a barrier to the larger goal of Medicaid, which is to provide access to health care for our nations' most vulnerable populations.

Sincerely,

Milt Camhi
Interim Chief Executive Officer

cc: Robyn Thaw, San Francisco Health Plan
Carl Maier, Inland Empire Health Plan
Janie Tyre and Mary Ellen Sweeny, Santa Clara Family Health Plan
David Hurst, Health Plan of San Joaquin
Amanda Flores-White, Alameda Alliance for Health
Andrea Van-Hook, L.A. Care Health Plan
Wendy Mailer, Contra Costa Health Plan
Louie Iturriria, Kern Family Health Plan
Robert Menezes, San Francisco Health Plan
Katie Trueworthy, LHPC Policy Director

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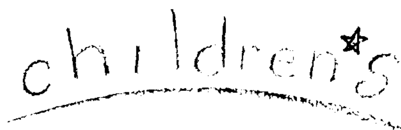
C A L I F O R N I A



H O S P I T A L

A S S O C I A T I O N

August 4, 2006

3914 MURPHY CANYON ROAD
SUITE 125
SAN DIEGO, CA 92123

858.974.1644
FAX: 858.974.1629

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Citizenship
Documentation Interim Final Rule,
71 Fed.Reg. 39214 (July 12, 2006)

Dear Sir/Madam:

I am writing on behalf of the Board of Directors of the California Children's Hospital Association to express concern about the interim final rule, which was published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). This provision of the DRA became effective on July 1 and requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity.

The policies set forth in the regulation could have a very significant impact on the patients served by children's hospitals in California. Medicaid provides a vital safety net that allows children to access essential medical services. For the eight private, non-profit children's hospitals in California, Medicaid is the primary payer of services comprising on average 50 percent of the caseload. Three of the hospitals have caseloads well over 60 percent.

While we appreciate the fact that CMS has included some provisions in the interim final rule that address the unique circumstances of children under the age of 16, we are still very concerned that without modifications there is a strong likelihood that access to Medicaid coverage will be delayed and/or denied for children who are U.S. citizens. The regulations will also impose an undue financial burden on children's hospitals, as we will not be compensated for care provided to children otherwise eligible for Medicaid until and unless the documentation requirements are satisfied.

Below are the comments of California's children's hospitals, which highlight a number of areas that we believe CMS should modify in the final rule.

<u>Exemption for Children</u>

We recommend that CMS exempt children who are eligible for federal foster care payments from the new documentation requirements. These children already provide documentation to prove citizenship through the foster care eligibility process. Requiring this group of children to present documentation a second time is burdensome and unnecessary. When Medicaid eligibility for children in foster care is delayed, foster parents will not be able to receive essential non-emergency care until

the child's condition deteriorates to the point that it requires emergency care in the already over-burdened hospital emergency departments at a cost much higher than routine care. A highly-likely side effect of diminished access to health care for these already vulnerable children will be the withdrawal of foster parents from the program.

We also ask that CMS add all children to the list of vulnerable groups that states must assist in accessing the documents necessary to demonstrate citizenship in part because children must rely on others -- their parents or guardians -- to collect this information.

Nationwide, children represent more than half of all Medicaid recipients. These same children face the greatest risk of inappropriate denial of necessary health care should they not be exempted from the documentation requirements. Children's hospitals believe that the requirements put forth in this regulation add barriers to accessing health care that will likely add to the six million children who are eligible for Medicaid but not enrolled. While we recognize that CMS does not have the authority to exempt children from this new requirement, we urge you to work with Congress to accomplish this policy.

Children who are U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements

We urge CMS to revise the regulation to state that children who declare they are U.S. citizens or nationals and who meet the state's Medicaid eligibility criteria are eligible for Medicaid, and that states must provide them with Medicaid coverage while they have a "reasonable opportunity" period to obtain the necessary new documentation. There is nothing in the DRA that would prohibit CMS from implementing such a policy.

As an alternative, for children who are otherwise eligible for the Medicaid program, CMS could allow a parent or guardian to use an affidavit as evidence of both identity and citizenship during the "reasonable opportunity" period while they are locating other documentation. This would allow a child who is a U.S. citizen to receive Medicaid benefits immediately.

The prohibition on granting children Medicaid coverage until they provide documentation of their citizenship will delay access to care, which will likely worsen health problems. As providers of health care services to low-income children, children's hospitals will not receive Medicaid payment for services rendered until and unless the documentation has been assembled and presented to the state Medicaid agency.

In addition, we urge CMS to clarify that existing retroactive eligibility is not impacted by the new regulations. Retroactive eligibility allows Medicaid applicants to get coverage retroactive to three months prior to application. Maintaining retroactive eligibility will ensure that children receive needed services. Furthermore, it will ensure that children's hospitals are reimbursed for services they provide to citizen children who have applied for Medicaid and been determined eligible, but who are waiting for birth records or identity documentation.

Application to Newborns

The preamble to the regulation states that newborns whose mothers are categorically eligible for Medicaid are deemed eligible and remain eligible for one year as long as the mother remains eligible. Despite this categorical eligibility at birth, these infants will be required to produce citizenship documentation for "re-determination" at their first birthday. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year bar on Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to continue to be covered by Medicaid, an application must be filed and the citizenship documentation requirements would apply immediately.

We recommend that CMS amend its list of acceptable documents to prove citizenship and identity to include a state Medicaid agency's record of payment for these children. When Medicaid has paid for the birth of a child in a U.S. hospital, the child is by definition a U.S. citizen.

Requiring Medicaid agencies to obtain additional documentation is unnecessary and redundant. Additionally, mandating that these parents obtain this new documentation could interrupt care. Since birth certificates can take months to obtain, children's hospitals are at high risk for delayed or denied payments for often-expensive treatment of low birth weight babies and those with post-partum complications.

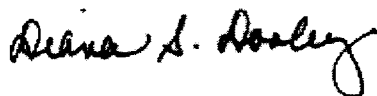
Requirement of Originals and Certified Copies
We recommend that CMS allow states to accept copies or notarized copies of required documentation. The requirement that only originals and certified copies be accepted as satisfactory documentary evidence of citizenship will add to the burden of the new requirement on applicants, beneficiaries, and state Medicaid agencies. CMS proposes in the interim final rule that it will only take an applicant or beneficiary ten minutes and state Medicaid agencies five minutes to satisfy the requirements of the regulations. Requiring that individuals obtain and submit originals and certified copies will add to the time compliance will take. In addition to locating or obtaining their documents, applicants and beneficiaries will also have to visit state offices to submit them, as it is unlikely that individuals will choose to submit such important documents by mail. State agencies, in turn, will have to meet with individuals, make copies of their documents, and maintain record. In the case of a child, he or she will have to rely upon a parent or guardian to take the necessary steps to obtain original or certified copies of the accepted documents.

We would also recommend that CMS work with states to implement electronic systems to establish citizenship. Programs that can identify Medicaid records nationwide, enrollment in other local, state, and federal programs that require proof of citizenship, and birth record matching should be developed and encouraged to ease the burden on Medicaid applicants, beneficiaries, states, and providers.

Conclusion
Representing more than half of all Medicaid recipients, and dependent upon adults to act for them, children are an especially vulnerable population that will be adversely impacted by these new documentation requirements. The delay in eligibility determination for children who apply for Medicaid will also impact payments to providers, such as children's hospitals, which jeopardizes the financial stability of the entire health care system.

We appreciate the opportunity to present comments on the interim final rule to implement section 6036 of the DRA. Thank you for your consideration.

Sincerely,



Diana S. Dooley
President & CEO
California Children's Hospital Association

CALIFORNIA STATE ASSOCIATION OF COUNTIES

CALIFORNIA MENTAL HEALTH DIRECTORS ASSOCIATION

COUNTY HEALTH EXECUTIVES ASSOCIATION OF CALIFORNIA

CWDA

COUNTY WELFARE DIRECTORS ASSOCIATION

August 9, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8017
Baltimore, Maryland 21244-8017
Attention: CMS-2257-IFC

Dear Sir/Madame:

The California State Association of Counties, County Welfare Directors Association of California, California Mental Health Directors Association and the County Health Executives Association of California are writing to comment on the interim final rule published in the Federal Register on July 12 to implement the Medicaid citizenship documentation requirements under Section 6036 of the Deficit Reduction Act of 2005 (DRA). While there are improvements in the interim final rule's provisions compared to the June 9, 2006 guidance, there continue to be a number of proposed requirements that are unnecessarily burdensome for Medicaid applicants, recipients and public agencies.

The Centers for Medicare and Medicaid Services (CMS) has failed to avail itself of administrative flexibility given to it in some portions of the statute, while being overly proscriptive in other areas. As currently drafted, the interim final rule will delay or deny Medicaid coverage to many U.S. citizens, leaving the entire fiscal responsibility of serving these patients to county hospitals and other providers of health care to low-income families. Many who are sick will delay seeking treatment until their health care needs become emergencies. Our suggested changes will minimize the likelihood that Medicaid-eligible citizens are determined ineligible due to administrative provisions created by CMS in the rule.

In California, counties act on behalf of the state to determine initial and ongoing eligibility for Medicaid benefits. Counties also provide health, mental health, substance abuse and in-home support services paid for in part by the federal government as Medicaid-reimbursable services. For these reasons, California counties have a substantial stake in the content of the final rule.

We have organized our comments by category in the attachment. Please do not hesitate to contact any of us if you have questions.

Sincerely,

Kelly Brooks, Legislative Representative
California State Association of Counties

Frank J. Mecca, Executive Director
County Welfare Directors Association of California

citizens when it is far simpler for non-citizens to demonstrate their satisfactory
immigration status than for citizens to demonstrate their citizenship under the interim

final rule. The unnecessary delays in coverage will be exacerbated in the short term due to the lack of a federal outreach program to educate citizens about the requirements.

Information Collection Requirements: Original and Certified Copies

Comment: The interim final rule requires that only originals and certified copies of documents be accepted as satisfactory proof of citizenship. Additionally, it is estimated that it will only take an applicant or recipient ten minutes and county or state agencies five minutes to satisfy this requirement.

Nothing in the DRA requires original or certified copies of documents. While the interim final rule allows applicants and recipients to mail the originals or certified copies of passports or birth certificates, it is highly questionable that most will be willing to do so.

The process will also delay receipt of Medicaid benefits, and reverses the progress made to simplify the eligibility process throughout the country. As in many states, applicants in California are not required to go to their local human services department for a face-to-face interview; the application process can be completed via mail and over the phone. Imposing a requirement that originals or certified copies must be viewed by the county will create substantial new administrative demands on the eligibility system, as well as on the federal, state and local agencies that produce original documents. We are also concerned that some Medicaid-eligible individuals will chose not to apply for benefits due to the time that they will need to take from work to go to an appointment and/or their coverage will be delayed while waiting for their appointment. We also find that the estimated time of five or ten minutes to find or otherwise acquire the necessary documents is completely unrealistic. The estimate serves to artificially minimize what we foresee as a large administrative burden.

Recommendation: Revise this requirement to allow state and county agencies to accept copies or notarized copies of documents. Our caseworkers should be given the flexibility to accept copies when the agency has no reason to believe that the documents provided were altered, counterfeit or otherwise questionable.

Additionally, we recommend revising the requirement to allow for a confirmation from a source agency that a document exists to suffice for the purposes of documenting citizenship and identity. For example, if a California county receives confirmation from another county's vital records agency or a vital records agency in another state that a birth certificate is available for a particular individual, that should meet the requirement for an original document without requiring the California county or the individual to order a certified copy.

Requiring Documentation for Children Receiving Title IV-E Benefits

Comment: While CMS officials have spoken publicly that they intend to define children in foster care as "recipients," enabling them to qualify for Medicaid, there is no language in the regulation to that effect. More than 80,000 children in California alone would have to comply with this provision. Abused and neglected children (especially young children) who are removed from their parents' custody cannot be expected to sign declarations of U.S. citizenship under penalty of perjury. Moreover, the parents who have abused, neglected or abandoned these children are unlikely to sign such a declaration or otherwise cooperate by obtaining and submitting documents for children who are removed from their custody. Unlike parents of other children who receive Medicaid

benefits, these parents do not apply on their children's behalf to receive Title IV-E or Medicaid assistance; rather, the state makes this application when it becomes involved with the family via the child welfare system. The purpose of the Deficit Reduction Act's (DRA) Medicaid citizenship documentation requirements is to prevent potential fraud by individuals seeking to qualify for Medicaid benefits. There is no evidence that any parent has abused or neglected their children for the purpose of securing Medicaid benefits for their children through the foster care system.

While we welcome the possible change in the final rule to consider foster care children who receive Medicaid due to their Title IV-E link as recipients, these children would still be required to provide the necessary citizenship documentation and identification during a reasonable opportunity period. The declaration of citizenship and satisfactory immigration status requirements in Section 1137(d) of the Social Security Act ("Act") do not apply to the Title IV-E program. Moreover, under section 1903(a)(10)(A)(i)(1) of the Act, all children receiving Title IV-E assistance are entitled to Medicaid benefits, and do not separately apply for Medicaid.

It is noteworthy that, because Medicaid eligibility for Title IV-E children is not determined on a household or family basis, an adult member of the child's family or household is not allowed to sign a declaration of citizenship or satisfactory immigration status, pursuant to section 1137(d)(1)(A). Even if it were allowed, Medicaid eligibility and federal financial participation (FFP) for foster children should not be contingent on the cooperation of their absent parents to make such a declaration.

State and local agencies that administer Title IV-E already establish whether the citizenship or immigration status of children make them eligible for FFP. They should not be required to apply two sets of standards – one for Title IV-E and another for Medicaid. Nothing in the DRA's legislative history suggests that Congress intended that be done. Doing so would impose unnecessary increased administrative costs and burdens on Title IV-E agencies in California because the interim rule's citizenship documentation procedures vary from those currently used.

In California, if a foster child's derivative citizenship through the naturalization of his/her parents can be established with the assistance of U.S Citizenship and Immigration Services (CIS) of the Department of Homeland Security (DHS), an otherwise eligible child appropriately will be determined to be eligible as a citizen for purposes of Title IV-E (and indirectly Medicaid) even if the child lacks a U.S. passport or certificate of citizenship. In contrast, under the interim rule a passport or certificate of citizenship must be obtained for such a child, and it would be costly, complicated, and take time to obtain such documents, especially without the cooperation of the child's parents. Verification of a Medicaid recipient's citizenship status by DHS should be acceptable, just as DHS verification of satisfactory immigration status currently is acceptable for purposes of Medicaid eligibility and federal financial participation. The lack of a particular citizenship document should not preclude an individual whose citizenship has been verified from receiving Medicaid benefits.

Recommendation: CMS should avail itself of the administrative flexibility granted to it under the Deficit Reduction Act (DRA) and exempt Title IV-E recipients from the DRA's citizenship documentation requirements. CMS should not require that a declaration of U.S. citizenship or satisfactory immigration status be in the Medicaid file of each Title IV-E child. Title IV-E and other foster care children who are eligible for other programs requiring citizenship documentation should be exempt from this duplicative requirement.

Under section 1137(d) of the Act, such a declaration is not required for purposes of Title IV-E eligibility or FFP, and it does not make any sense to require children who qualify for Medicaid by virtue of their receipt of Title IV-E to make such a declaration. Foster children, especially very young children, cannot be expected to know their citizenship or immigration status.

Alternatively, the rule should allow a juvenile court finding regarding the identity of the child to be used to establish identity and citizenship. All Title IV-E children go through court proceedings through which their identity is established, so there is not any reason to, in effect, require child welfare agencies to obtain an identification card for each child receiving Title IV-E. This revision also would be consistent with how the interim final rule in 42 CFR Part 403.407(e)(10) provides States with the option to use a cross match with the data system of State public assistance agencies, including child protective services agencies (Title IV-E agencies), to establish an individual's identity if the agencies established and certified the identity of individuals.

To the extent that CMS requires the original document or copies certified by the issuing agency, we urge that a copy of the computer match be considered sufficient evidence for purposes of the case record and potential compliance audits.

Children Born in U.S. Hospitals

Comment: The interim final rule allows a hospital record of birth as a 'third level' form of evidence documenting citizenship. Obviously, newborns will not have a birth certificate on file with the state or county nor a passport, but it is not logical to question an infant's citizenship when the baby was born in a U.S. hospital and Medicaid has paid for the birth. Current law also deems infants born to U.S. citizens as eligible for Medicaid. The child's citizenship status will not change after the initial period of eligibility expires.

Recommendation: CMS should accept documentation of a state's Medicaid agency payment for the birth of a child as satisfactory evidence of citizenship.

Procedures for U.S. Citizens Unable to Document Citizenship

Comment: County agencies interact with some of the most vulnerable individuals in their communities, including the homeless, persons with severe mental illness and those who have lost all of their possessions in a disaster. Even with the assistance of state or county agencies, some individuals will never be able to provide documents proving citizenship. Rules for the Supplemental Security Income (SSI) provides flexibility in allowing individuals who cannot provide documents to explain why that is the case and to provide information that they do have in their possession.

Recommendation: CMS should give a state the option to certify that it has determined that an individual meets the requirements of the statute if it can demonstrate that it has exhausted its search of allowable documents and finds it is reasonable to conclude that the individual is a U.S. citizen or is otherwise in the U.S. legally.

Allowable Documentation

Comment: We welcome CMS's decision to take advantage of the flexibility given to it under the DRA to adopt additional means of verifying citizenship and identity beyond the limited options listed in statute.

<u>Recommendations:</u> As we recommended in our comments on the June 9, 2006 guidance, we urge that the rule allow states to accept copies of otherwise acceptable documents if a state accepts copies of that document for any other federal means-tested public benefit program. This will promote consistency across existing programs. Additionally, we recommend that acceptable documentation of citizenship for other federal means-tested public benefit programs be considered acceptable documentation for purposes of Medicaid.

Additionally, we recommend that any citizenship document or verification method that is acceptable to the Social Security Administration be accepted by CMS for purposes of Medicaid verification. The interim final rule already allows SSA verifications to be used for SSI recipients; it is a logical next step to allow for the documents and methods used by SSA to also be allowed for states and counties verifying eligibility for Medicaid applicants and recipients who are not receiving SSI.

Finally, we recommend that the CMS clarify that costs incurred by a county or state agency in assisting applicants and recipients, including, but not limited to, costs incurred to purchase copies of birth certificates or other documents identified by CMS as among those that may be used to establish U.S. citizenship, are allowable administrative costs for federal financial participation.

Below, we suggest a few additional, specific documents that should be included in the list of acceptable documentation for citizenship or identity.

<u>Recommended Additional Citizenship Documents:</u>

a. Marriage certificate showing place of birth of the individual.

b. Tribal enrollment card, Bureau of Indian Affairs identification card, and certificate of degree of Indian blood. These cards are allowed in the interim final rule purposes of identification but not for citizenship. We recommend they be allowed for documentation of both.

c. Religious record recorded in the U.S. within three months of birth, which is acceptable secondary evidence of citizenship for purposes of obtaining a Social Security number.

d. Entries in a family bible documenting birth in the United States.

e. For a parent, a U.S. birth certificate of a child showing the parent's place of birth.

f. Acceptable evidence of derivative U.S. citizenship, which is accepted by the Department of Homeland Security for purposes of issuing a Certificate of Citizenship or by the Department of State for purposes of issuing a passport. This will avoid the high cost and delay of obtaining the necessary evidence of citizenship that immigrant and adopted children derive through their parents. The application fee for a passport is $97 ($82 if under age 16) and $255 ($215 if an adopted child) for a Certificate of Citizenship. The normal processing time is six weeks for a passport and much longer for a Certificate of Citizenship.

Recommended Additional Identity Documents:

a. ID card with photo issued by a current employer. Employers are required to document that the prospective employee is legally in the U.S. before hiring the individual.

b. ID card with photo issued by a private agency, such as the Salvation Army, providing social services.

c. Government-issued papers not related to public assistance, such as a tax return, property tax statement, Social Security Award letter.

d. A combination of two of the following documents:
   - Rent receipt with landlord/manager signature and telephone number.
   - Bill for medical/dental treatment.
   - Bill for utilities.
   - Bank statement.
   - Bills/statements for credit cards.
   - Envelope addressed to the individual with a postmark date prior to the date of application.

Naturalized Citizens

Comment: For naturalized citizens, the acceptable documentation for Medicaid purposes is far more limited than currently allowed by the Social Security Administration for purposes of obtaining a Social Security number (SSN) card.[1] Under the interim final rule, the acceptable citizenship documents for virtually all naturalized United States citizens are limited to a U.S. passport, certificate of naturalization, or certificate of citizenship.[2] Unlike U.S.-born citizens, the interim final rule does not allow naturalized citizens to use affidavits. Moreover, the interim final rule does not allow state Medicaid agencies to verify citizenship with U.S. Citizenship and Immigration Services (CIS) in the Department of Homeland Security (DHS), which has the capacity to verify naturalized citizenship status. The CIS currently verifies the immigration status of all Medicaid applicants and recipients who declare that they have satisfactory immigration status pursuant to Section 1137(d) of the Social Security Act ("Act").

This limitation on acceptable citizenship documents will be extremely problematic for the numerous naturalized citizens who will likely lack these documents. The number of naturalized citizens has been growing far more rapidly than the number of native-born U.S. citizens. Between 1990 and 2004, the number of naturalized citizens increased from 8 million in 1990 to more than 13.1 million, according to U.S. Census Bureau estimates. Moreover, in 2004, 1.328 million naturalized citizens had incomes below the poverty level and 17.2 percent lacked health insurance.[3]

A significant number of naturalized citizens are likely to lack a U.S. passport or certificate of citizenship/naturalization, because children under age 18 who derive their citizenship

[1] See Social Security Administration's (SSA) Program Operations Manual (POMS) Section RM 00203.310 Evidence of U.S. Citizenship for an SSN Card.
[2] The only other possible citizenship documents are a U.S. Citizen Identification Card issued from 1960 to April 1983 to naturalized citizens living near the Canadian or Mexican borders or evidence of U.S. Civil Service employment before June 1, 1976, both of which will not be possessed by the vast majority of naturalized citizens.
[3] Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004"

through the naturalization and/or citizenship status of their parent(s) do not receive any of these documents when they become citizens. The interim final rule fails to take into account that lawful permanent resident children under age 18 and foreign-born adopted children typically do not file a separate naturalization application to become U.S. citizens. Instead, they derive their citizenship through the naturalization/citizenship of their parents. Unlike their parents who receive a certificate of naturalization, a child who receives derivative citizenship must apply to CIS for a certificate of citizenship as documentary evidence of citizenship. Most children who receive derivative citizenship do not immediately apply for a certificate of citizenship, and many, if not most, never have done so. In all likelihood, Medicaid-eligible individuals are less likely to have obtained a certificate of citizenship, given the relatively high cost of obtaining one.

As explained in greater detail below, a U.S. passport, certificate of naturalization or certificate of citizenship will be difficult, time-consuming and costly for Medicaid eligible individuals who are naturalized citizens to obtain, which means that limiting acceptable citizenship documentation to these three documents will be a major barrier to the receipt of Medicaid benefits for numerous naturalized citizens. The relatively high cost of obtaining such documents is likely to prevent many of them for receiving needed Medicaid benefits. For applicants who ultimately obtain and present such documents, the interim rule will significantly delay their receipt of benefits.

Below is a detailed explanation of the difficulty and cost of obtaining a certificate of citizenship, certificate of naturalization, and U.S. passport. It will take naturalized citizens who must obtain these documents far more than the five minutes estimated by CMS to acquire and provide acceptable documentation (see 71 Federal Register 39220). Moreover, it will be even more complicated for child protective agencies to obtain such acceptable documents for Title IV-E foster children because their natural parents often times are not cooperative or impossible to locate in cases where parents abandon their children and then move out-of-state.

> Certificate of Citizenship: The current application fee for a certificate of citizenship, which is the only permanent record of citizenship for persons who derived/acquired U.S. citizenship through their parent or parents, is $255 ($215 for an adopted child). Additional costs associated with obtaining such a certificate include the cost of passport photos, a certified foreign birth certificate, if necessary, and travel to and from the CIS office for a required in-person interview by CIS officer. An applicant may have to travel hundreds of miles to the nearest CIS office because there only are 79 CIS offices, excluding those located in Puerto Rico and U.S. territories. The vast majority of states have a single CIS office, and there are not any CIS states located in Alabama, Mississippi, North Dakota or South Dakota. Including travel costs, the total cost of obtaining a certificate of citizenship easily can exceed $500.
>
> The high cost of obtaining a certificate of citizenship can prevent very-low-income individuals from obtaining one, thereby also preventing them from receiving Medicaid benefits. It will be especially costly for low-income families with children. While there is no cost for a legal immigrant family, headed by two parents, with three children to document their satisfactory immigration status for Medicaid eligibility purposes, it would cost them $765 alone in application fees to obtain a certificate of citizenship for each child after having paid a combined total of $800 in naturalization application fees for the parents. It is noteworthy that, if the children had become naturalized citizens, they still would have qualified for

Medicaid as qualified aliens, provided that they met the five-year residency requirement.

Besides the high cost of obtaining a certificate of citizenship, Medicaid applicants also will be penalized by the long time that it takes to obtain such documentation. It can take nearly two years to obtain a certificate of citizenship, depending upon the CIS office. As of July 17, 2006, the Phoenix office was interviewing persons who submitted applications on September 30, 2004. In California, the backlog extends back to March 1, 2005 for the Fresno office and January 5, 2006 for the Los Angeles office. Under the interim final rule, an otherwise eligible Medicaid applicant will not be provided Medicaid benefits until they have submitted satisfactory documents.

Certificate of Naturalization: The current application fee for a replacement certificate of naturalization (or citizenship) is $220, and there is an additional cost for the passport photos that must be submitted with an application. It can take longer than one year to obtain a replacement certificate of naturalization. In fact, given the long delay, CIS' A Guide to Naturalization recommends that naturalized citizens apply for a U.S. passport to more quickly obtain documentation of citizenship.

U.S. Passport: In lieu of obtaining a certificate of citizenship/naturalization, naturalized citizens, including those who received derivative citizenship, may obtain a U.S. passport as proof of U.S. citizenship. However, the U.S. Passport Agency in the Department of State verifies citizenship independent of DHS, and its passport records are not linked to automated DHS data bases, including the System for Alien Verification for Entitlements (SAVE) database used to verify eligibility for public assistance entitlements and employment. Moreover, U.S. passports expire. Therefore, many naturalized citizens do not apply for passports unless needed for foreign travel. Low-income Medicaid-eligible individuals, especially those with major health problems, are far less likely to travel outside of the country, and, therefore, also are far less likely to have U.S. passports.

The application fee for a passport, which has a normal processing time of six weeks, is $97 ($82 if under age 16). The cost of an expedited passport, which is processed within two weeks, is an additional $60 plus overnight delivery fees. There is an additional cost of passport photos that must be submitted with an application. In addition for children under age 18, parents will incur additional costs associated with travel to a passport-issuing office because children must appear in person. For child protective agencies, obtaining a passport will be even more complicated as they will have to show legal guardianship and make arrangements for foster children to appear in person.

In practice, it will be difficult and also take time for Medicaid applicants and recipients to prepare and submit passport applications. In fact, it may not be possible for most naturalized citizens who lost their certificates of naturalization (or citizenship) to obtain a U.S. passport. According to passport application instructions, a certificate of naturalization or certificate of citizenship must be submitted with a passport application. Although it is not explained in the application instructions, the U.S. Passport Agency will provide a passport with an expiration date of approximately one year to a naturalized citizen who submits a

"letter of verification" issued by DHS or a U.S. District Court indicating that he/she is a naturalized citizen. Many naturalized citizens, however, will not be able to obtain such letters. This is because DHS no longer issues letters of verification except on a very limited emergency case-by-case basis due to concerns that such letters are vulnerable to document fraud, and because the U.S. District Court only issues letters for persons who naturalized before October 1994. Moreover, a receipt for a replacement certificate of naturalization application is required to obtain a letter of verification as well as a U.S. passport, adding $220 to the cost of obtaining a passport. In practice, it is highly unlikely that Medicaid applicants and recipients will know how to obtain a passport without a certificate of naturalization. This is because the U.S. Passport Agency does not publicize how to do so, and DHS and U.S. District Courts do not publicize how to obtain a letter of verification that is needed to obtain a passport without a certificate of naturalization.

In sum, limiting acceptable citizenship documents for naturalized citizens to a U.S. passport, certificate of naturalization, or certificate of citizenship inappropriately will greatly delay or prevent the receipt of Medicaid benefits to a large number of naturalized citizens. In turn, this would result in higher uncompensated health costs for health providers, especially for public hospitals and other safety net providers. Obtaining such documents will be especially burdensome for child protective agencies responsible for IV-E foster children.

Recommendations: Revise the interim final rule to provide Medicaid applicants and recipients, as well as state and local Medicaid agencies, with more options for documenting satisfactory citizenship status. Specifically, the interim final rule should be revised to allow states to use and accept the following methods of verification:

1. Any method for verifying citizenship that is acceptable for proving citizenship for purposes of obtaining a Social Security number (SSN) card under the Social Security Administration's (SSA) Program Operations Manual System (POMS) guidelines. States then would be allowed to verify citizenship status against DHS' SAVE data base – the same verification system currently used by states to verify satisfactory immigration status, as required under Section 1137(d) of the Social Security Act, and the same data base used by many employers to verify work authorization for new job hires.

   SSA allows staff to query SAVE in recognition of the fact that DHS has citizenship data for all naturalizations from 1906 to present and that what matters is whether an individual actually is a U.S. citizen, not whether someone has possession of a particular document. In order to ensure integrity of the information provided, POMS guidelines require that DHS be requested to manually verify citizenship when an automated SAVE records match does not verify satisfactory citizenship or immigration status.

   The interim final rule should provide citizens with the same protections afforded to legal immigrants. Low-income naturalized citizens who lack a passport, certificate of naturalization, or certificate of citizenship, therefore, should not be required to undergo the major cost and time of obtaining such documents when their citizenship can be verified by DHS. Enabling states to use any method for documenting citizenship that is acceptable for SSN purposes also would greatly simplify implementation of the new citizenship requirements for states. Instead of

developing new internal instructions, states would be able to take advantage of the detailed POMS instructions already developed by SSA. This is especially justified because, under the interim final rule, SSA guidelines already, in effect, are being used to verify citizenship in states in which Supplemental Security Income (SSI) recipients receive Medicaid by virtue of receipt of SSI.

2. The SAVE database, including through secondary verifications with DHS, as explained in the previous recommendation on allowing any documentation that is accepted by SSA.

3. Copies of a U.S. passport, certificate of naturalization or certificate of citizenship. The validity of copies can be verified with the U.S. Passport Agency or DHS, if necessary. This would ease the burdens on low-income Medicaid applicants and recipients of having to obtain replacement documents as well the administrative burdens on state and local Medicaid agencies. It is highly unlikely that applicants and recipients will mail important original documents, which means that they, instead, will be required to present documents in person, greatly increasing traffic at offices. There will be an especially huge workload increase in states such as California that use a mail-in process for Medicaid eligibility and redeterminations.

4. Signed affidavits submitted by naturalized citizens accompanied by copies of any supportive documents and/or information, such as the date of naturalization, alien registration number, and, in the case of persons who received derivative citizenship, information on their parent's naturalization. Unlike affidavits submitted by persons born in the U.S. who lack birth records, all naturalization cases can be verified by DHS. Yet, the interim final rule inappropriately precludes the use of affidavits by persons born outside the U.S.

5. A letter of verification or any other official document from the Department of Homeland Security (DHS) or a U.S. District Court indicating that a person is a naturalized citizen. The rule should allow an individual to use any official government document indicating citizenship status. Such documents should be considered secondary evidence of citizenship.

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Universal Health Care Action Network of Ohio

Working for health care justice

August 5, 2006

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

Re: Medicaid Citizenship Documentation
Interim Final Rule, 71 FR 39214
(July 12, 2006)

Dear Secretary Leavitt:

UHCAN Ohio is a statewide, nonprofit organization working for quality, affordable health care for all Ohioans, through education, community engagement, and policy advocacy. We work extensively with health and social service providers, community organizations, religious organizations and others to link uninsured people with Medicaid and other available programs and resources. We have also worked for years to reduce barriers to Medicaid enrollment for those who are eligible for the program. We are writing to comment on the Interim Final Rule on Citizenship Documentation, which was published in the Federal Register on July 12, and implements § 6036 of the Deficit Reduction Act of 2005 (DRA).

First, we incorporate by reference and endorse the comments submitted by Steve Hitov, managing attorney of the National Health Law Program, dated August 3, 2006. We refer to those comments for the legal arguments forming the basis for our comments.

Second , we thank CMS for improvements in the Rule as published from the earlier SMDL # 06-012. Chief among the improvements is the exclusion from the documentation requirements of all Medicare beneficiaries and most of those receiving SSI. Also, allowing states to do a vital records match in lieu of requiring a birth certificate to establish citizenship, and to consult federal or state governmental, public assistance, law enforcement or correction agency's data systems to establish identity are also both important improvements over the earlier CMS guidance in this area. Finally, we are pleased with the clarification that presumptive eligibility remains for children, pregnant women and women with breast and cervical cancer during the presumptive eligibility period regardless of whether they have documented their citizenship.

Unfortunately, although better than previous guidance from CMS, the Rule still contains burdensome requirements not mandated by § 6036 of the DRA that will keep eligible citizens from receiving Medicaid. Our major requests for changes in the rule are:

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1. U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements.
The Rule as written converts the provision of documentary evidence of citizenship into an eligibility requirement for citizen Medicaid applicants, as it prohibits states from providing medical assistance to a person before presenting that evidence. Applicants who need medical benefits promptly will delay or forego receiving needed care, even though they meet all state requirements, either because they are unable to obtain documents or are waiting to obtain documents, such as an out-of-state birth certificate. At the same time, providers will suffer delays or go without payment for services provided to patients who are unable to comply. This clearly flies in the face of Congressional intent and violates Medicaid law. As explained in comments submitted by the National Health Law Program, this approach is not legally permissible and will deprive eligible American citizens from Medicaid and the health care they need.

CMS should, by amending 42 C.F.R. § 435.407(j) or otherwise, clarify that applicants for Medicaid who declare they are citizens or nationals of the United States must, if otherwise eligible, be given Medicaid benefits during the reasonable opportunity period they have to acquire evidence of their status.

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2. A state Medicaid agency's record of payment for the birth of an infant in a U.S. hospital should be considered satisfactory documentary evidence of citizenship and identity.

In Ohio, Medicaid pays for one out of three births. CMS should amend 42 C.F.R. § 435.407(a) or (b) to include a record of Medicaid payment for a child's birth as acceptable evidence of that child's citizenship, regardless of the immigration status of the child's mother. It should also clarify that no child whose birth was paid for by Medicaid needs to document his or her citizenship for at least the first year. A child born in the US is by definition a U.S. citizen, a fact known to the Medicaid agency because it will have paid for the child's birth in a U.S. hospital. CMS should instruct states not only that they may, but that they must, accept a record of Medicaid (or other insurance) payment for a birth in a U.S. hospital as sufficient proof of citizenship.

3. CMS should also exempt certain other categories of Medicaid recipients and applicants who have already established their citizenship for other government benefit programs. The most obvious group in this category is comprise of *former* beneficiaries of Medicare or SSI, *i.e.*, people who have been on either of those programs in the past (at least since 1996 and perhaps from some earlier date) but who no longer are for whatever reason. It is the fact of having already established citizenship that is the basis for exempting current Medicare and SSI recipients. That fact does not change simply because a person is now, for example, over the asset limit for SSI and therefore no longer eligible for that program. CMS should therefore clarify that proof of previous receipt of Medicare or SSI will also exempt a person from the citizenship documentation requirements.

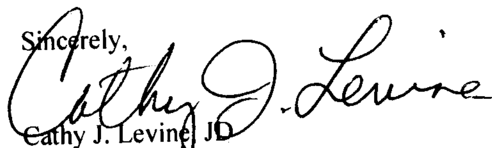
4. CMS should allow photocopies of qualifying documents to be accepted to verify citizenship or identify. The Rule, at § 435.407(h)(1), specifies that only originals or certified copies of qualifying documents may be accepted to verify citizenship or identity. If § 435.407(h)(1) is not amended, it will effectively reinstate the requirement that people apply for Medicaid in person, because few people will be willing to send original, costly documents through the mail to the county Medicaid office. Requiring people to appear in person to protect

their documents will have an especially burdensome impact on working families, many of whom cannot take time off from work without jeopardizing their jobs, and people with disabilities. Requiring originals or certified copies will certainly increase the cost of acquiring any necessary evidence, and it will almost as certainly require people who already have documents such as birth certificates to acquire new copies that comply with this gratuitously burdensome provision. Finally, many people fill out Medicaid applications at hospitals, clinics or other venues where they go to seek medical care.

CMS should amend 42 C.F.R. § 435.407(h)(1) to say that states must accept standard copies of qualifying documents and must accept the documents from whomever the beneficiary has designated to deliver the documents.

Thank you for considering these comments in determining how to improve the proposed Rule so that we protect citizens' access to health care services through Medicaid.

Sincerely,



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