NATIONAL
FAMILY
PLANNING &
REPRODUCTIVE
HEALTH
ASSOCIATION

August 9, 2006

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

To Whom It May Concern:

On behalf of the National Family Planning and Reproductive Health Association (NFPRHA), an organization that represents more than 4,000 family planning clinics across the United States, I am deeply concerned about several of the provisions of the interim final rule published on July 12, 2006, concerning new requirements for citizenship documentation under Medicaid. **Specifically, we urge CMS to modify §435.406 and §436.406 of the interim final rule to allow individuals receiving benefits under section 1115 family planning demonstrations to attest to citizenship in order to comply with the statute.** If implemented, this rule would impede access to critical, time-sensitive and cost-effective care and severely limit the ability of these innovative state-initiated programs to enable low-income women to avoid unplanned pregnancy.

NFPRHA is a non-profit membership organization that has served as an important source of advocacy, education, and training for the family planning and reproductive health care field for more than 35 years. Our mission is to ensure access to family planning and reproductive health care services for all. We represent providers of care: public, private, domestic and international, as well as researchers, educators, consumers, and advocates. NFPRHA members provide health care services at more than 4,000 clinics to more than 4 million women annually.

Importance of Medicaid-Funded Family Planning. Publicly funded family planning services are critical to helping low-income women avoid unplanned pregnancy. These services prevent an estimated 1.3 million unplanned pregnancies each year. Without these services, our nation's unplanned pregnancy rate would be 40 percent higher than it is. Medicaid is playing an increasingly important role in funding these services, providing six in 10 of all public dollars spent for family planning. Nationwide, each dollar spent to provide publicly funded family planning saves $3 in expenditures for pregnancy-related and newborn care just to the Medicaid program alone.

NFPRHA is deeply concerned that instituting cumbersome procedures for documenting citizenship will prevent large numbers of low-income women in need of publicly funded family planning services from being able to enroll in Medicaid, even if they are American citizens who are otherwise eligible. Such a result would be particularly tragic at this moment in time, when the need for publicly funded family planning is rising—a million more women have joined the ranks of those in need just since 2000—while public funding targeted for family planning is stagnating or even declining.

Recent trends are disturbing. According to data from the latest National Survey of Family Growth, middle- and upper-class women are continuing decades of progress in reducing unplanned pregnancy and the need for abortion. At the same time, however, poor women are facing more unplanned pregnancies. Since 1994, unplanned pregnancy rates among poor women rose by 29 percent, even as rates among higher income women fell by 20 percent. In 2001, a poor woman was four times as likely to have an unintended pregnancy, five times as likely to have an unintended birth and more than three times as likely to have an abortion as her higher-income counterpart.

Women who qualify for Medicaid should be able to enroll in the program. If precluded from doing so because of the cumbersome requirements for citizenship documentation, many will nonetheless seek services from publicly funded family planning clinics. But with public funding for family planning services having declined or stagnated in half the states over the last decade, clinic budgets are already stretched almost to the breaking point. And if clinics are unable to meet this need, these low-income citizens, who would otherwise qualify for Medicaid, may ultimately be unable to access the care they need to avoid unplanned pregnancy.

Section 1115 Family Planning Waivers. Over the past decade, 24 states have obtained federal approval in the form of a waiver under section 1115 to expand eligibility for family planning services and supplies under Medicaid to individuals who otherwise would not be covered. These programs provide a narrow set of benefits, as defined by the terms of their approval by CMS.

These programs have had a significant impact. A national evaluation of several of these efforts conducted under a contract with CMS found evidence that the programs expanded access to care and improved the geographical availability of services. All six states studied surpassed the federal requirement that the programs be budget neutral, producing millions of dollars in savings to both the federal and state governments.

By throwing what could be a sizable impediment in the path of individuals seeking to enroll in these programs, the interim final rule could turn the clock back on this progress, threatening the access to care, reductions in unplanned pregnancy and cost-savings that have been a hallmark of these programs. Many low-income women will likely be hard-pressed to meet the documentation requirements of the interim final rule, especially when only original documents or "copies certified by the issuing agency" are considered acceptable. The problem posed by the documentation requirements is particularly acute when it comes to accessing such a time-sensitive service as family planning.

Moreover, the cost of enforcing the citizenship documentation requirement for individuals applying for coverage under the 1115 family planning demonstrations are likely to be especially significant when compared to the extremely low cost of the limited set of benefits covered. As a result, implementing these requirements would significantly increase the cost per enrollee, a cost that would be shared by both the federal and state governments.

NFPRHA therefore urges CMS to modify §435.406 and §436.406 of the interim final rule to allow individuals receiving benefits under section 1115 family planning demonstrations to attest to citizenship in order to comply with the statute. Requiring these individuals to document citizenship using the processes described in the interim final rule would delay or even preclude the receipt of this time-sensitive care, resulting in an increase in unplanned pregnancies, unplanned births, and the need for abortion among low-income Americans. Denying women access to this cost-effective care would result in significant costs to both the federal and state governments.

Respectfully Submitted,

Marilyn J. Keefe

Marilyn Keefe
Vice President of Public Policy

American Cancer Society

August 11, 2006

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

RE: Interim Final Regulations on Citizenship Guidelines for Medicaid Eligibility

Dear Dr. McClellan:

On behalf of the American Cancer Society and its millions of volunteers and supporters, we respectfully submit the following comments for your consideration regarding the new Medicaid citizenship documentation requirement in the Centers for Medicare & Medicaid Services' (CMS') interim final regulations, CMS-2257-IFC, as published in the Federal Register on July 12, 2006.

As the nationwide voluntary health organization committed to eliminating cancer as a major health problem, the American Cancer Society has a particular interest in ensuring that Medicaid beneficiaries who have cancer have access to high quality cancer prevention, early detection, and treatment services. We are concerned that the interim final regulations may not provide adequate clarification on the types of assistance states can provide applicants and renewals nor sufficient flexibility for states to implement the documentation requirement in a manner that protects both program integrity and the need for the rapid access to care for cancer patients.

We already know that cancer is a disease where upfront financial costs are substantial and that timely treatment and follow up care is absolutely critical upon diagnosis. We also know that access to screening and quality cancer care can have a significant effect on outcomes. The interim final regulation implementing the new documentation requirement may inadvertently limit Medicaid beneficiary access to the full continuum of quality cancer care. For example:

- ***Medicaid coverage could be delayed or denied for women diagnosed with breast or cervical cancer*** through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). All states currently expedite these eligibility determinations so that these women can immediately access lifesaving treatment. Delayed or denied Medicaid eligibility will impair access to treatment with adverse consequences for women and for the state breast and cervical screening programs.

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- ***Current Medicaid beneficiaries who are citizens may lose Medicaid coverage and lose access to ongoing treatment for cancer.*** Inability to produce necessary DRA documentation at renewal could result in loss of Medicaid benefits. This could be devastating for women enrolled in Medicaid through NBCCEDP precisely for the purpose of receiving treatment for breast or cervical cancer or for other enrollees receiving Medicaid benefits because of job loss and income loss as a result of cancer.

The Society has had a longstanding interest in protecting cancer patients' access to high quality care. Therefore, we urge CMS to implement the DRA requirement without creating undue burden on citizens with cancer who may not be able to provide the required citizenship documentation. We ask that CMS consider giving states more flexibility and discretion, for example, by allowing citizens with cancer renewing their Medicaid a reasonable amount of time to collect the required documentation or exempting them from producing their proof of citizenship until after completion of cancer treatment.

We also request that CMS provide clarification on the type of assistance states should provide to Medicaid applicants and beneficiaries in obtaining citizenship documents. Such assistance should be specified to ensure that individuals with critical medical needs, such as cancer or other chronic diseases, can access the care they need in a timely manner.

Conclusion

The final regulations have the potential to affect millions of Medicaid beneficiaries, including many diagnosed and living with cancer. We appreciate CMS' efforts in continuing to work with states to provide this important safety net and urge you to ensure that implementation of the DRA citizenship documentation requirement does not impede the greater goal of the Medicaid program – to provide access to care for our nation's most vulnerable populations.

We stand ready to work with you and your staff to meet our mutual goals of improving the health and reducing the cancer burden among Medicaid beneficiaries.

Respectfully,

Daniel E. Smith
National Vice President
Federal and State Government Relations

Wendy K. D. Selig
Vice President
Legislative Affairs

NATIONAL OSTEOPOROSIS FOUNDATION

Standing Tall For You®

August 10, 2006

Mark McClellan, MD
Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
445-G
200 Independence Avenue, SW
Washington, DC 20201

Attention:

Re: CMS-1513-PN
Medicare Program; Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense and Methodology

Dear Administrator McClellan:

Introduction

On behalf of the National Osteoporosis Foundation (NOF), thank you for the opportunity to comment on the Center for Medicare and Medicaid Services Five Year Review of Work Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense and Methodology. This letter and its comments address Code 76075 – Dual energy x-ray absorptiometry (DXA) a bone density study at one or more sites of the axial skeleton (e.g. hips, pelvis, spine).

NOF is the nation's leading voluntary health organization solely dedicated to osteoporosis and bone health. Its mission is to prevent osteoporosis, promote lifelong bone health and help improve the lives of those affected by osteoporosis and related fractures and find a cure. NOF achieves its mission through programs of awareness, advocacy, public and health professional education and research. NOF is a leading authority for anyone seeking up-to-date, medically-sound information and educational material on the causes, prevention, detection and treatment of osteoporosis.

Osteoporosis

Osteoporosis is a disease characterized by low bone mass and structural deterioration of bone tissue, leading to bone fragility and an increased

susceptibility to fractures, specially of the hip, spine and wrist, although any bone can be affected.

Osteoporosis is the most common bone disease in humans. In the United States, it is a public health threat for 44 million Americans, 55 percent of the people 50 years of age and older. Ten million Americans are estimated to already have the disease and almost 34 million more are estimated to have low bone mass, placing them at increased risk for osteoporosis. Of the ten million Americans with osteoporosis, eight million are women and two million are men.

Osteoporosis often is called a "silent disease" because bone loss occurs without symptoms. People may not know that they have osteoporosis until their bones become so weak that a sudden strain, bump or fall causes a fracture or a vertebra to collapse. Collapsed vertebrae may initially be felt or seen in the form of severe back pain, loss of height, or spinal deformities such as stooped posture.

Risk factors, such low body weight or use of steroid drug, increase the likelihood of specific people developing osteoporosis and fractures. Individuals either at risk for or with osteoporosis may be prescribed a bone mineral density test (BMD). These tests not only identify osteoporosis and predict a person's risk for fractures, but they also monitor an individual's response to an osteoporosis treatment.[i] Central dual x-ray absorptiometry (DXA), which may measure the hip and/or spine, is the preferred measurement for definitive diagnosis and monitoring of the effects of therapy.[ii]

Attitudes, Practices and Policies

Even though the majority of women aged 45 and older have at least two risk factors for osteoporosis, only 15 percent of those women not diagnosed by a doctor believe they are at risk for the disease. Women do not perceive themselves to be personally at risk for osteoporosis despite its prevalence.[iii]

Ninety-five percent of those who suffer an osteoporotic fracture are never evaluated or treated for the disease, concluded a Consensus Development Conference convened by the National Institutes of Health in 2000.[iv]

Beginning mid-1998 and recently highlighted in the announcement of a "Welcome to Medicare" visit, Medicare covers BMD testing for five categories of individuals. Coverage includes all women who are estrogen-deficient, and men and women with certain risk factors. Despite the fact that this would include all women age 65 and older, for the three-year period from 1999-2001, only 22.9 percent of females over the age of 65 had bone density tests, according to a study based on Medicare claims.[v]

In September 2002, the US Preventive Services Task Force (USPSTF) urged routine osteoporosis screening for all women age 65 and older to identify those at

risk for fracture and that routine screening begin for women age 60 at increased risk for osteoporosis fractures.[vi]

The Health Plan Employer Data and Information Set (HEDIS) has incorporated a fracture measure that tracks the percentage of women age 67 and older who were diagnosed with a fracture and who received either a BMD test or prescription drug treatment within six months of the date of fracture. In 2003, the first year the measure was included, national data indicate that only 18 percent of female Medicare beneficiaries who had a fracture received either a BMD or a prescription. Only about 3 percent of women age 67 or older received both, considered the highest standard of care. (Another measure tracking women's own responses to whether they have had a BMD test was introduced this year.)

The US Surgeon General released a report on bone health and osteoporosis in October 2004. The report's major messages are that osteoporosis will continue to double or triple in the next few decades without any action; and that although research continues to be necessary, there is much that can be done that is not being done with what already is known about preventing, diagnosing and treating osteoporosis. The Surgeon General further states that unless the US acts now, "in 2020 one in two Americans over the age of 50 will have, or be at high risk of developing, osteoporosis." [vii]

The estimated annual national direct care expenditures (including hospitals, nursing homes and outpatient services) for osteoporotic fractures is $18 billion in 2002 dollars, and the cost is rising.[viii] The overall lifetime cost attributable to a hip fracture, the most devastating type of fracture, could be more than $81,000.[ix] "Among women over age 45, the government pays for most of the costs of osteoporotic fractures: Medicaid covers almost a fourth of the expense and Medicare pays nearly half."[x] A recent study of disease management in a rural healthcare population demonstrated that a preventive program was able to reduce hip fractures and save money.[xi]

The World Health Organization (WHO) is in the process of developing a standardized methodology for expressing absolute fracture risk in women and men based on clinical risk factors with and/without bone mineral density. The project has been directed by Dr. John Kanis. In collaboration with Dr. Kanis, NOF plans to determine the absolute fracture risk of women and men age 50 and older in the US. These data then will be exposed to economic modeling to determine the absolute fracture risk at which treatment might be recommended. This will alter the landscape for BMD testing in the very near future.

Proposed Rule

The proposed Medicare rule reduces the average payment for a central DXA from approximately $140 to $40. This includes an 80 percent reduction in the technical component and a 50 percent reduction in the physician component.

Comments on Overall Impact

Overall response to:

What will this mean to individuals at risk for or with osteoporosis?
How will it affect their prevention, diagnosis and treatment of osteoporosis?

Osteoporosis is not an inevitable consequence of aging but a disease that is largely preventable. For years, NOF has been working to educate the public, healthcare professionals and policymakers about osteoporosis. Currently, there is general agreement among interested healthcare professionals and policymakers that not enough is being done to prevent, diagnose and treat osteoporosis. After a comprehensive study leading to the release of his report, the US Surgeon General issued a call to action on this very issue.

Now CMS has determined that imaging services are over-utilized and that reimbursement for BMD testing, specifically central DXA (hip and spine), is too high. NOF has worked for years to increase utilization of BMD testing – to prevent, diagnose and treat osteoporosis. Unfortunately, the current rate at which this is occurring is still very low (as documented above under "Policy Environment") comparable to other disease testing.

Individuals at risk for osteoporosis often do not think they are at risk and thus, do not engage in beneficial behaviors. A risk factor assessment, coupled with BMD testing, as appropriate, can determine overall risk for the disease and subsequently, for fracture, so that preventive and/or therapeutic measures may be taken. Likewise, if therapies are prescribed, there is a need to monitor whether they are working appropriately for an individual patient. It is interesting to note that: "The relationship between BMD and fracture is stronger than the relationship between cholesterol and heart attack, and as strong as the relationship between blood pressure and stroke."[xii]

Access to Bone Mineral Density Testing

The proliferation of DXA systems in physicians' offices has made it easier for a patient to be tested in conjunction with a visit to their physician. Physicians tell us that the proposed decrease in services will make it very difficult to justify purchase of new equipment and to continue providing DXA exams. If access to DXA tests becomes more difficult, the rate at which individuals are tested will decline from an already low rate (documented above). If more time needs to be spent traveling to a facility other than a physician's office that may be further away, and for which the deductible may be higher, such as in an outpatient hospital setting, the likelihood of patients being tested is reduced. Those in rural areas may experience this hardship to an even greater degree because of fewer facilities and the greater distance between them.

This runs counter to the expert opinions expressed in various federally sponsored policy forums, such as the 2000 National Institutes of Health Consensus Conference and the 2002 Surgeon General's Workshop on Bone Health and Osteoporosis. It also runs counter to federal recommendations and reports, such as the US Preventive Services Taskforce Recommendations on Osteoporosis and the 2004 US Surgeon General's report on bone health and osteoporosis; and it runs counter to programs and policies advanced and supported by NOF.

Quality of Care

Because NOF views central DXA as the preferred measurement for definitive diagnosis and monitoring the effects of therapy, decreased reimbursement for this test may open the door to physicians reverting to less expensive technologies. Whereas other methods do assess bone density and may provide an indication of fracture risk," the WHO and other guidelines for using BMD and interpreting BMD results for diagnosis are based on DXA measurements of the hip or spine."[xiii]

In addition, quality of care for those with or at risk for osteoporosis depends on the ability of the person who gives the DXA exam, the working order of the machines on which it is given, and the knowledge of the professional who interprets the test. Quality of care demands adequate training for those giving BMD tests, appropriately calibrated machines, and knowledgeable, experienced physicians to evaluate the results of the tests. Clearly, education, time and money all enter into this equation.

Also, physicians who diagnose osteoporosis span a spectrum of medical specialties – from rheumatologists and endocrinolgists to gynecologists and family physicians. Thus, it is even more important that the selection and interpretation of a BMD test adhere uniformly to the highest standards of care, regardless of with whom the patient consults for their medical expertise. If reimbursement is low for the central DXA exam, the most widely accepted method for measuring BMD, patients may be shortchanged. This runs counter to years of professional education and training by NOF.

(Please note that sections of these comments, particularly the second paragraph under "Quality of Care," also address practice expense and physician's work component.)

Conclusion

In conclusion, NOF is very concerned about how the reduction in Medicare reimbursement for Code 76075, central DXA test, will affect access to and quality of care for individuals with and at risk for osteoporosis. For years, NOF and

federal policymakers have encouraged prevention of osteoporosis, and when this is not possible, they have encouraged early diagnosis and treatment to alleviate the severity of the disease and reduce the risk for fracture. Now federal policymakers are concerned about over-utilization of a relatively inexpensive test that has the ability to reduce the incidence of highly costly hip fractures, costly not only in terms of economic dollars, but also costly in terms of their physical and emotional toll. And, large portions of the bill for these fractures are paid for by government agencies, such as Medicare and Medicaid. Surely, there is a disconnect.

NOF urges you to reevaluate the reduction in reimbursement for Code 76075, taking into consideration the arguments put forth in this document as well as others presented by various medical specialty societies. By reviewing the entire scope of concerns surrounding this reimbursement reduction, we urge you, above all, to consider the patient, who often gets lost in the fray of technical arguments. If patients have limited access and lesser quality of healthcare, we all have lost sight of our objectives. After all, the ultimate goal we all strive for is to simplify access to improved healthcare so that patients can live longer and have a more productive and fulfilling life.

As NOF moves forward, and hopefully, the federal government advances to encourage those individuals at risk for or with osteoporosis to seek appropriate healthcare, we look to agencies such as the Centers for Medicare and Medicaid Services to lead the way toward more enlightened and scientifically-based public health policies.

Thank you again for the opportunity to comment on the proposed rule, and if we can provide additional information upon which to base your final rule, please do not hesitate to contact Roberta Biegel, senior director of public policy and government relations at 202-721-6364 or roberta@nof.org.

Sincerely,

Thomas Einhorn MD

Thomas A. Einhorn, MD
Co-chair, Advocacy Committee

Conrad Johnston MD

C. Conrad Johnston, Jr., MD
Co-chair, Advocacy Committee

Citations:

[i] U.S. Department of Health and Human Services. *Bone Health and Osteoporosis: A Report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Office of the Surgeon General, 2004: 198.

[ii] The National Osteoporosis Foundation. *Physician's Guide to Prevention and Treatment of Osteoporosis*. Washington, DC, 2004: 14.

[iii] Roper Public Affairs (Commissioned for the National Osteoporosis Foundation). *Health Issues Survey: Attitudes and Actions Regarding Osteoporosis*. January 2004: 32.

[iv] Osteoporosis Prevention, Diagnosis, and Therapy. NIH Consensus Statement Online 2000 March 27-29; [2006, August, 3]; 17(1): 1-36.

[v] Neuner JM, et al. Bone density testing in older women and its association with patient age. Journal of the American Geriatric Society 2006 Mar; 54(3):485-9.

[vi] U.S. Preventive Services Task Force. *Screening for Osteoporosis in Postmenopausal Women: Recommendations and Rationale*. September 2002. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/3rduspstf/osteoporosis/osteorr.htm

[vii] U.S. Department of Health and Human Services: 4.

[viii] U.S. Department of Health and Human Services: 93.

[ix] U.S. Department of Health and Human Services: 94.

[x] U.S. Department of Health and Human Services: 94.

[xi] Newman ED et al. Osteoporosis disease management in a rural health care population: hip fracture reduction and reduced costs in postmenopausal women after 5 years. Osteoporos Int. 2003 Feb; 14(2):146-51. Epub 2003 Feb 18.

[xii] U.S. Department of Health and Human Services: 198.

[xiii] U.S. Department of Health and Human Services: 200.

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March of Dimes
Saving babies, together

August 9, 2006

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

Attention: Medicaid Program; Citizenship Documentation Requirements Comments (Interim Final Rule, CMS-2257-IFC)

Dear Secretary Leavitt:

The March of Dimes Birth Defects Foundation submits the following comments in response to the Interim Final Rule addressing Citizenship Documentation Requirements to implement section 6036 of the Deficit Reduction Act of 2005 (DRA) published by the Centers for Medicare and Medicaid Services (CMS). The March of Dimes is a unique collaboration of scientists, clinicians, parents, members of the business community, and other volunteers affiliated with 52 chapters in every state, the District of Columbia and Puerto Rico.

These comments will focus on three areas of concern to the March of Dimes. First, the Interim Final Rule does not guarantee continuous coverage for pregnant women receiving services under presumptive eligibility, resulting in the potential denial of services to pregnant women eligible for coverage through Medicaid. Second, the proposed documentation requirements for newborns would impose a significant burden on parents, resulting in a lack of coverage for newborns and infants. Finally, there is no clear rule or guidance on the citizenship documentation and identity requirements for individuals and families who have lost their documentation due to natural disasters.

1) Presumptive Eligibility and Gaps in Coverage

Prior to enactment of the DRA, a woman whose care was covered through presumptive eligibility, in the twenty-one states using presumptive eligibility as a coverage option, had access to reimbursable services until a final determination was made on her eligibility to enroll in Medicaid. As a consequence, the pregnant woman was able to continue seeing her health care provider during the time it took to gather the necessary documents and process her application. Under the policy in effect prior to enactment of the DRA, State Medicaid agencies had 45 days to make an eligibility determination after an application was filed, and states could determine

within that time period, how much time an applicant would be given to submit required documents (including income information and legal immigration status).

As proposed, the Interim Final Rule would jeopardize access to care for pregnant women receiving coverage under presumptive eligibility by failing to state that a woman will remain continuously covered during the time she has to obtain her documents and the time the State Medicaid agency takes to process her application and verify her documents:

> "Individuals who receive Medicaid because of a determination by a qualified provider, or entity, under sections 1920, 1920A, or 1920B of the Act (presumptive eligibility) are not subject to the documentation requirements until they file an application 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, including the requirements of section 1903(x) of the Act. However, when these individuals file an application for Medicaid and declare on the application that they are citizens or nationals, these regulations would apply for periods in which they receive services as eligible for Medicaid." 71 Fed Reg 39216

The March of Dimes recommends that CMS amend the Interim Final Rule to add a new section to ensure continuous access to reimbursable care for pregnant women. This new section should clearly state that once a pregnant woman receiving services under presumptive eligibility files an application for Medicaid, she remains eligible from the time when she has to obtain and present her citizenship and identity documentation through the state Medicaid agency's processing and verification of her application. This policy would adhere to the DRA's documentation requirements while leaving intact current policy to provide continuous access to prenatal care.

To maintain the health of a pregnant woman and her unborn child, continuous access to prenatal care is essential. *Guidelines for Perinatal Care*, the clinical standard for care of pregnant women developed jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics states:

> "Women who have early and regular prenatal care have healthier babies. Generally, a woman with an uncomplicated pregnancy should be examined approximately every 4 weeks for the first 28 weeks of pregnancy, every 2-3 weeks until 36 weeks of gestation, and weekly thereafter. Women with medical or obstetric problems may require closer surveillance."[1]

Gaps in coverage could result in a pregnant woman missing crucial prenatal medical appointments. Lack of adequate, regular prenatal care is associated with poor birth outcomes, including prematurity (born before 37 completed weeks of gestation.) or low birthweight (less than 5 ½ pounds). Prematurity is the leading cause of neonatal death. Low birthwieght is a factor in 65 percent of infant deaths. Low birthweight babies may face serious health problems as

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[1] American College of Obstetricians and Gynecologists and American Academy of Pediatrics. *Guidelines for Perinatal Care*. 2002. p. 54.

newborns, and are at increased risk of long-term disabilities. Infants born to mothers who did not receive regular prenatal care in 2002 were about twice as likely to be low birthweight as infants born to mothers who received early and adequate prenatal care.[2]

Conversely, women who do receive sufficient prenatal care are more likely to have access to screening and diagnostic tests that can help identify problems early; services to manage developing and existing problems; and education, counseling and referral to reduce risky behaviors like substance abuse and poor nutrition. Such care may thus help improve the health of both mothers and infants, reducing their future healthcare costs.[3]

2) Documentation Requirements for Newborns and Infants

The Interim Final Rule proposes applying the citizenship and identity documentation requirements to all U.S. citizen children except those eligible for Medicaid based on their receipt of Supplemental Security Income (SSI) benefits. Among the children subject to the documentation requirements are infants born in U.S. hospitals. The birth records of such infants may not be on file with state vital statistics agencies due to application or processing delays. In such circumstances, 42 CFR 435.407(c)(1) provides that extracts of hospital records created near the time of birth may be used as proof of citizenship. However, if this "third level" of evidence is unavailable, under 42 CFR 435.407(d) a medical (clinic, doctor, or hospital) record created near the time of birth could be used, but only in the "rarest of circumstances." Therefore, a newborn's health insurance record, including a record of Medicaid payment for birth in a U.S. hospital, would not satisfy the threshold established by the Interim Final Rule.

In the case of an infant born in a U.S. hospital to a mother who would not remain Medicaid eligible after giving birth, the interim final rule fails to take account of the logistical difficulties associated with providing documentation of citizenship and identity. By requiring citizenship and identity documentation for newborns, the Interim Final Rule clearly puts infants at risk for delay or denial of medical treatment. Access to health care services, particularly for infants with significant medical needs associated with birth defects or complications of prematurity is vital and should not be delayed or denied while citizenship determinations are being made. A gap in coverage while parents attempt to fulfill documentation requirements for their newborn could result in disruption of needed medical care and even death for the most medically fragile newborn.

To ensure that these infants have access to continuous care, the March of Dimes recommends that 42 CFR 435.407(b) be amended to allow for continuous coverage of infants until such time as the newborns application for enrollment in Medicaid is processed.

We note that the American Academy of Pediatrics has submitted comments specifically regarding documentation requirements for newborns which raise issues that warrant careful consideration. In view of the complexity and precedent setting nature of the significant change in policy contemplated by the Interim Final Rule, it is the recommendation of the March of

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[2] National Center for Health Statistics. 2002 final natality data. Data prepared by March of Dimes Perinatal Data Center, 2005.

[3] "Benefits from and Barriers to Prenatal Care," in McCormick, M.C., and others. 1999. *Prenatal Care: Effectivness and Implementation.* Cambridge University Press, Cambridge, England.

Dimes that CMS consider convening a meeting of experts to develop a carefully crafted policy statement that both protects newborns' access to coverage and satisfies the statutory requirements pertaining to documentation and verification of citizenship.

3) Victims of Natural Disasters

A third concern with the Interim Final Rule is the absence of explicit guidance on the processes that states should follow in the event of a natural disaster where all records, forms of identification and documentation of a pregnant woman or child are lost. For example, if a family's citizenship and identity documents are destroyed in the course of a tornado, hurricane or other natural disaster, the family would face tremendous barriers to Medicaid eligibility — at a time when they could be in the greatest need of healthcare services.

Acceptance of affidavits to prove citizenship and identity as proposed in 42 CFR 435.407(d)(5) for other situations in which required documents are unavailable, is not a sufficient solution for victims of natural disasters. The family, friends or neighbors who would be required to sign the affidavits may themselves be victims of the disaster and therefore unable to provide their own necessary documentation.

To address this problem, the Foundation recommends that the final rule allow individuals and families who are victims of natural disasters to be given five months of access reimbursable services under Medicaid beginning on the date of the natural disaster's occurrence. Additional coverage should be provided for pregnant women through 60 days postpartum. Newborns should be covered for the remainder of their mother's coverage period. Eligibility should be determined during this time based upon an individual's self-declaration of his or her circumstances. According to officials at Florida's Department of Children and Families—the agency tasked with determining Medicaid eligibility in that state, Florida's recent experience with post-hurricane health coverage suggests that this approach to providing temporary access to Medicaid reimbursable services to hurricane victims has proven effective. When the five month period ends, individuals and families wishing to remain eligible for Medicaid services are required to submit traditional eligibility documentation. The March of Dimes recommends that states continue to have flexibility to address the needs of victims of natural disasters who must meet the new citizenship and identity documentation requirements.

In closing, the March of Dimes is confident that CMS aims to ensure that continuous access to health services for pregnant women, infants, and children with special needs is protected under the final rule governing citizenship and documentation requirements for Medicaid. We offer our comments in the hope that they provide constructive ideas useful in securing those protections. Thank you for your consideration.

Sincerely,

Dr. Marina L. Weiss
Senior Vice-President, Public Policy and Government Affairs
March of Dimes

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Center on Budget and Policy Priorities

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August 10, 2006

Centers for Medicare & Medicaid Services
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ATTN: CMS-2257-IFC

RE: Comments on Medicaid Citizenship Documentation Interim Final Rule, 71 *Federal Register.* 39214 (July 12, 2006) and Collection of Information Requirements

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded twenty-five years ago, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting low- and moderate-income families and individuals. We appreciate the opportunity 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).

We were pleased to see that the Secretary recognized the "scrivener's error" made by Congress in drafting section 1903(x)(2), as added by the DRA, and has clarified in the interim final regulations that Medicare beneficiaries and, in most states, Supplemental Security Income (SSI) recipients are exempt from the citizenship documentation requirements. However, we are deeply concerned and disappointed that the Secretary has not exercised the discretion afforded to him under the statute to minimize the likelihood that numerous other U.S. citizens applying for or receiving Medicaid coverage – primarily low-income children, pregnant women and parents – will face delay, denial, or loss of Medicaid coverage. We are particularly troubled that the Secretary did not ease the burden of the new rules to the extent possible on new applicants; foster care children receiving title IV-E benefits; Social Security Disability Insurance recipients; and individuals who, despite making a good faith effort to comply with the documentation requirements, simply cannot produce any of the specific documents identified in the interim regulation. We estimate that roughly 38 million current recipients remain subject to the citizenship documentation requirements, and that approximately 10 million citizen applicants who meet all Medicaid eligibility requirements will be subject to the requirements in the next year.[1]

[1] This estimate, based on analyses of Medicaid administrative data as well as analyses of the Agency for Healthcare Research and Quality's 2003 Medical Expenditure Panel Survey, will be presented in "Documenting Citizenship and Identity Using Data Matches," by Leighton Ku, Donna Cohen Ross and Matt Broaddus, Center on Budget and Policy Priorities, forthcoming. We adjusted these estimates to exclude counts for Medicare and SSI beneficiaries.

In the following comments we (1) suggest ways that the Secretary can alleviate the unnecessary burden that the current rule imposes on these populations and (2) respond to the Secretary's solicitation for comments and suggestions on the use of other electronic data matches and other documents that could reliably establish citizenship. We also comment on the impact that requiring submission of original or certified copies of the requisite documents will have on the collection of information requirements, and have sent a copy of our comments to the appropriate Offices at the Centers for Medicare and Medicaid Services and the Office of Management and Budget.

Finally, while we agree that changes to immigrant eligibility for Medicaid made by the Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) make it appropriate for the Secretary to remove the regulations at 42 CFR 435.408 and modify the regulations at 42 CFR 435.406, we are concerned that the Secretary has (1) inadvertently omitted some groups of legal immigrants who are eligible for Medicaid and (2) inappropriately required states to verify the immigration status of others with the Department of Homeland Security.[2]

COMMENTS ON PROVISIONS OF INTERIM FINAL RULE AND PREAMBLE IMPLEMENTING SECTION 6036 OF THE DRA

Section I. Background, *Implementation Conditions/ Considerations* (42 CFR 435.407 and 435.1008)

1. *U.S. citizens applying for benefits should receive benefits once they declare they are citizens and meet all eligibility requirements (435.407(j)).*

   Under the DRA, the new citizenship documentation requirement applies to all individuals who apply for Medicaid, unless otherwise exempt from the requirement under the regulation. The preamble to the rule states that applicants "should not be made eligible until they have presented the required evidence." 71 *Federal Register* at 39216. The interim rule itself 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." 42 CFR 435.407(j).

   As noted, the new documentation requirement has the potential to delay or deny Medicaid coverage for up to 10 million U.S. citizens who will apply for Medicaid this year, most of whom will be children, pregnant women and parents. To not permit enrollment until all documents are produced could delay, or result in a denial of access to, medical care, including prenatal and early childhood services, impair health and jeopardize the financial status of health care providers who may otherwise be forced to serve these women and children on a charity basis.

   While an individual must be a citizen or qualified alien to receive full Medicaid benefits, *documentation* of citizenship is not itself a criterion of Medicaid eligibility. We note that, under section 1137(d) of the Social Security Act ("Act"), Congress did expressly make an

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[2] Please note that, where we have made specific suggestions in ways in which the regulations should be modified, we have identified only the pertinent section in Part 435 of the interim final regulations. In each instance, we would urge the Secretary also to make conforming changes to the corresponding section of Part 436 of the interim final regulations.

individual's *declaration* of citizenship or qualified alien status a condition of eligibility.[3] In adding subsection 1903(x) to the Social Security Act, Congress has required states to document citizenship as a condition of receiving Federal financial participation (FFP). Congress did not, however, make documentation of citizenship a criterion of eligibility *per se.* Therefore, once an applicant for Medicaid declares that he or she is a citizen, and the State determines that the individual meets all other eligibility requirements, medical assistance should be made available, and the individual should be afforded the same reasonable opportunity as beneficiaries to provide the requisite documentation of citizenship.

Since the enactment of the Immigration Reform and Control Act of 1986, states have had to apply similar documentation requirements under §1137(d) of the Act to immigrants, as those now applied to citizens under the DRA. Sections 1137(d)(2) and 1137(d)(3) require states to obtain documentation of immigration status from immigrant applicants and to verify such status with the United States Citizenship and Immigration Services (USCIS). Under §1137(d)(4), states are required to give immigrant applicants a reasonable opportunity to submit the necessary documentation and, during such period, to provide medical assistance to otherwise-eligible immigrants. Although not expressly required under the DRA, there is nothing in the DRA that prevents the Secretary from affording citizen applicants the same treatment. Yet, the Secretary has declined to do so, requiring instead an unnecessary delay in coverage for citizens who cannot readily produce the required documentation.

The policy articulated in the preamble to the interim final regulations, while not statutorily compelled, has serious implications – implications which are both foreseeable and avoidable – for the vulnerable citizen populations who need medical assistance and for the providers who serve them. U.S. citizens who (1) have applied for Medicaid and (2) meet all of the state's eligibility criteria, but (3) are trying to obtain the necessary documentation, may experience significant delays in coverage. Some, who become discouraged or simply are unable to obtain the necessary documents within the time period provided by the state, will never get coverage. Providers will have to turn vulnerable patients away, or run the risk of not being compensated for critical services, and the health of these individuals may suffer. The use of emergency rooms to obtain services and the burden of uncompensated care will increase. The lack of an effective outreach program to educate U.S. citizens about the new requirement will further exacerbate these consequences, as most applicants are likely to be unaware of the new rules, and there are likely to be significant delays in assembling the necessary documents.

Therefore, we urge the Secretary to revise 42 CFR 435.407(j) as follows:

(1) If an individual declaring to be a citizen of national of the United States does not present satisfactory documentary evidence of citizenship at the time of application—
    (A) The State—
        (i) Shall provide the individual with a reasonable opportunity to submit such evidence to the State; and

[3] Section 1137(d)(1)(A) states, in pertinent part: "The State shall require, *as a condition of an individual's eligibility* for benefits under a program listed in subsection (b) [including Medicaid], a declaration in writing, under penalty of perjury ...stating whether the individual is a citizen or national of the United States..." (emphasis supplied)

(ii) May not delay, deny, reduce or terminate the individual's eligibility for benefits until such a reasonable opportunity has been provided.

(B) If, after a reasonable opportunity is provided to such individual, satisfactory documentary evidence of citizenship or nationality is not provided, the State shall—

(i) Deny or terminate the individual's eligibility for benefits under the program; and

(ii) Provide the individual with notice and opportunity for a fair hearing, in accordance with Part 431, Subpart E.

(2) Federal financial participation shall be provided in expenditures for medical assistance to such individuals whom the State Medicaid agency determines meet the State's Medicaid eligibility criteria during the reasonable opportunity period described in subparagraph (1).

2. *Children who are eligible for federal foster care payments should be exempt from the citizenship documentation requirement (42 CFR 435.1008)*

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 or Medicare. Among the children subject to the documentation requirements under the interim final regulations are roughly one million children in foster care, including those receiving federal foster care assistance under title IV-E – a population of extremely vulnerable children, often in need of immediate mental and physical health interventions, that will be unlikely to have access to the necessary documentation.

The DRA does not compel this result. Indeed, under the literal terms of the changes to the Act made by §6036 of the DRA, states should not be required to document the citizenship of children eligible for Medicaid by virtue of their title IV-E status. Section 1903(x) of the Act, as added by the DRA, requires states to verify the citizenship of individuals who have declared their citizenship as part of the Medicaid application process. Because Medicaid eligibility is automatically conferred upon title IV-E recipients, no such declaration of citizenship by, or on behalf of, these children is required. Thus, they need not, and should not, be subject to the new documentation requirements.

Even if the Secretary erroneously concludes that the terms of the DRA do apply to children receiving assistance under title IV-E, the Department of Health and Human Services' Agency for Children and Families (ACF) issued a Policy Interpretation Question (ACYF-CB-PIQ-99-01) which already requires state child welfare agencies to verify the citizenship of citizen children receiving title IV-E benefits. The ACF policy further requires that the agencies do so in accordance with the verification procedures set forth in the "Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility under Title IV of PRWORA," published in the *Federal Register*, Vol. 62, No. 221, on November 17, 1997. Nonetheless, the preamble to the interim final rule states that, in order to receive Medicaid, citizen children receiving title IV-E benefits "must have in their Medicaid file a declaration of citizenship ... and documentary evidence of the citizenship ... claimed on the declaration." 71 *Federal Register* at 39216.

The DRA does not compel the unnecessary duplication of state agency efforts, which puts these particularly vulnerable children at risk of delayed medical care. To the contrary, the DRA allows the Secretary to exempt individuals who are eligible for other programs that require documentation of citizenship. Title IV-E is precisely such a program. Therefore, we urge the Secretary to revise the second sentence of 42 CFR 435.1008 as follows:

> This requirement does not apply with respect to individuals declaring themselves to be citizens or nationals who are eligible for medical assistance
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> (i) on the basis of receiving supplemental security income benefits under title XVI of the Social Security Act or federal foster care payments under title IV-E of the Act; or
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> (ii) who are entitled to benefits or enrolled in any parts of the Medicare program under title XVIII of the Social Security Act.[4]

3. *Individuals eligible for Social Security Disability Insurance should be exempt from the citizenship documentation requirement (42 CFR 435.1008)*

The interim final regulation exempts Medicare beneficiaries who are applying for or receiving Medicaid from the citizenship documentation requirements. However, disabled individuals who are eligible for Social Security Disability Insurance (SSDI) benefits, but not yet entitled to Medicare, are not afforded comparable treatment – even though they automatically become entitled to Medicare Part A after receiving SSDI for 25 months.[5]

For purposes of the citizenship documentation requirements, there is no meaningful distinction between Medicare beneficiaries and SSDI recipients. Medicare entitlement is automatically conferred by receipt of either Social Security Old-Age Insurance or SSDI benefits under title II of the Social Security Act. Eligibility for both Social Security and SSDI, in turn, requires that the recipient be either a U.S. citizen, national or lawfully-present alien – a status which the Social Security Administration is required to verify. That SSA verifies the citizenship or immigration status of Medicare beneficiaries provides the rationale behind their exemption from the new citizenship documentation requirement under Medicaid. This same logic clearly supports the exemption of SSDI recipients from the Medicaid documentation requirements as well.

Moreover, SSDI recipients are automatically entitled to Medicare after a two-year waiting period. At that point, they will be exempt from the Medicaid citizenship documentation requirements. There simply is no rational reason to question their citizenship during the first two years of SSDI eligibility, any more than after they become eligible for Medicare. Accordingly, we urge CMS to revise the second sentence of 42 CFR 435.1008 as follows:

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[4] Note that we have an additional suggested revision to section 435.1008, discussed in the next section of our comments, below.

[5] Many SSDI recipients are eligible for Medicaid. A 2003 Commonwealth Fund report estimated that approximately 40% of SSDI recipients in the two-year waiting period for Medicare entitlement, or 500,000 SSDI recipients, were enrolled in Medicaid. (See "Elimination of Medicare's Waiting Period for Seriously Disabled Adults: Impact on Coverage and Costs," The Commonwealth Fund, July 2003). Moreover, states are required, as part of the Income and Eligibility Verification System (IEVS), to verify SSDI benefits, which they can do through the Social Security Administration's State Data Exchange (SDX).

This requirement does not apply with respect to individuals declaring themselves to be citizens or nationals who are eligible for medical assistance —

(i) on the basis of receiving supplemental security income benefits under title XVI of the Social Security Act, federal foster care payments under title IV-E of the Act, or Social Security Disability Insurance under title II of the Act; or

(ii) who are entitled to benefits or enrolled in any parts of the Medicare program under title XVIII of the Social Security Act;

4. *Additional electronic data matches which states should be permitted to rely upon in verifying citizenship (42 CFR 435.407(b))*

In the preamble, the Secretary solicited "comments and suggestions for the use of other electronic data matches with other governmental systems of records" (71 *Federal Register* 39216) that states can rely upon to verify citizenship and/or identity. We urge the Secretary to give states the option to use alternative types of cross matches with federal, state or private data sources to document citizenship, provided that the state describes such data or cross match in an amendment to its state plan. As with all state plan amendments, CMS would have the opportunity to review and approve or deny the proposed data match.

The interim final regulation permits electronic cross matches to document citizenship under very narrow circumstances: matches with state vital records or State Data Exchange (SDX) files for Supplemental Security Income beneficiaries. Other types of public or private data, however, may just as effectively document citizenship. It is shortsighted to foreclose the ability of states to use other electronic data matching opportunities that may be more effective or efficient in meeting the purposes of the law. For example:

- The Social Security Administration's NUMIDENT data base has data on the place of birth for virtually all people with Social Security numbers and data on citizenship for those who entered the system since 1972. SSA currently does not provide access to these data to CMS or states, but the interim final regulations would prohibit their use even if SSA were to grant access.

- States have found that the Department of Homeland Security's (DHS) Systematic Alien Verification for Entitlements (SAVE) system can be used to document whether a person is a naturalized citizen, but the regulations do not permit the use of SAVE data. DHS staff confirmed that SAVE has these data. This would be extremely useful, particularly in circumstances in which a naturalized citizen cannot find an original Certificate of Naturalization, which is the only document permitted under the interim rules. To get a replacement certificate requires payment of a prohibitive $220 fee and can take up to a year to obtain. States already participate in SAVE and can use it to get information about naturalized citizens more rapidly and less expensively.

Finally, it is quite likely that other federal, state or private data sources will be identified or developed in the near future that can meet these needs effectively. Information technology evolves rapidly and CMS should leave room for development of new and better approaches.

Therefore, we recommend that the Secretary add a new subparagraph (11) to 42 CFR 435.407(b) of the interim regulation to read:

> (11) *Other electronic verification of citizenship.* At State option and subject to approval by the Secretary, a State may use a cross match with a Federal, State or local governmental agency or private data system not specifically provided for in this section. The State must describe such cross match and data system in an amendment to its state plan.

Section II. Provisions of Interim Final Rule with Comment Period, (42 CFR 435.407)

The Secretary also solicited "comments and suggestions for additional documents that are a reliable form of evidence of citizenship...or identity" as well as "comments as to whether the number of documents accepted for proof of citizenship and identity should be limited" to first and secondary level documents "in light of the exception provided for citizens and nationals receiving SSI [in 1634 states] and for individuals entitled to or enrolled in Medicare." 71 *Federal Register* at 39219-20.[6]

We strongly urge the Secretary to use his authority to authorize a broader set of documents that can be used to establish citizenship and/or identity and to give more flexibility to states. As discussed elsewhere in our comments, there are many individuals, other than SSI recipients and Medicare beneficiaries, for whom the new documentation requirements pose a significant, if not insurmountable, burden in obtaining or retaining Medicaid benefits. To further constrain these individuals' ability to meet already stringent documentation requirements is neither necessary nor justified under the statute. On the contrary, the Secretary would be well-advised to expand the list of documents that may be used to satisfy the documentation requirements.

There are two specific types of documents that we urge the Secretary to add to the regulations as satisfactory evidence of both citizenship and identity: (1) Records of payment by Medicaid or the State Children's Health Insurance Program (SCHIP) for the birth of a Medicaid applicant or beneficiary in the United States; (2) tribal enrollment cards issued by a federally-recognized tribe. In addition, we strongly urge the Secretary to follow the approach taken by the Social Security Administration in verifying the citizenship of applicants for SSI, by granting states the ability to rely on other evidence of citizenship where an individual is unable to produce any of the documents identified in the regulations and the state finds it reasonable to conclude that the individual is a citizen for purposes of Medicaid eligibility.

1. *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 (Primary Evidence of Citizenship, 42 CFR 435.407(a))*

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[6] Preliminarily, we would like to note our support of the 42 CFR 435.407(d)(3) of the interim final regulation, which permits the use of institutional admission papers from a nursing facility or similar institution and does not limit reliance on such documents to those created at least five years before the initial application, as the guidance in the June 9, 2006 letter to State Medicaid Directors from Dennis Smith (SMDL 06-012) would have done. Only a small proportion of individuals remain institutionalized for more than five years. Thus, adding a five-year waiting period effectively would have precluded the use of such evidence for most institutionalized individuals.

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, and it may take several months or more for such agencies to even have a birth certificate on file. The interim 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).

Children born in the United States are, by definition, citizens.[7] If a state Medicaid or SCHIP agency or managed care organization (MCO) paid for the child's birth in a U.S. hospital, the state knows that the child was born in the U.S. and therefore knows that the child is a U.S. citizen. This is true, regardless of whether the child's mother is a citizen or qualified alien eligible for full Medicaid benefits, or an undocumented alien or legal immigrant subject to the five year bar and therefore eligible only for coverage of labor and delivery of the child. It also is true regardless of whether or not the child is entitled to deemed newborn eligibility under section 1902(e)(4) of the Act.[8]

Thus, a record of payment for a child's birth by the state Medicaid agency, the SCHIP agency or a Medicaid or SCHIP MCO reliably and conclusively establishes citizenship and should be acceptable evidence of such. Inasmuch as Medicaid alone pays for the delivery of more than 40 percent of all U.S. births, recognizing that a Medicaid or SCHIP record of payment for the birth establishes citizenship would significantly ease the burden created by the new requirements for states, providers and families.

All newborns, regardless of the immigration status of their mothers, need well-baby care. Those born prematurely or at a low birth weight, or who otherwise have post-partum

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[7] While virtually every child born in the United States is a U.S. citizen, there is, of course, an exception: Children born to foreign diplomats temporarily residing in the United States are not granted U.S. citizenship. We submit, however, that the number of foreign diplomats (or their wives) who give birth in the United States and whose labor and delivery is covered by Medicaid is negligible – probably non-existent.

[8] We note, however, that the policy regarding deemed newborn eligibility described in the preamble is incorrect, as it purports to limit the continued deemed newborn eligibility status to infants born to women who, not only were eligible for and receiving medical assistance at the time of the child's birth, but also who remain eligible for Medicaid during the child's first year of life. It appears that, in making this statement, the Secretary was relying on regulations at 42 CFR 435.117. These regulations, however, were superseded by a subsequent change to section 1902(e)(4) of the Social Security Act. Previously, the statute did require that, to retain the deemed eligible status for the full year, the infant's mother had to remain actually eligible for Medicaid. Section 1902(e)(4) of the Act now requires only that the mother was eligible for and received Medicaid at the time of birth, that the child remain a part of her household, and that the mother either remain eligible for Medicaid or that she would remain eligible if still pregnant.

The preamble correctly states that pregnant women who are undocumented aliens or subject to the five-year bar are eligible for Medicaid at the time of the child's birth, but incorrectly concludes that infants born to such women are not eligible for deemed newborn eligibility because the mother does not remain eligible for Medicaid after the child's birth. However, an undocumented or five-year bar woman mother, if still pregnant, would remain eligible for Medicaid, albeit only for emergency services, including for labor and delivery. As noted, the statute now provides that coverage of the infant should continue so long as the mother would, if pregnant, remain eligible for Medicaid. Accordingly, children born to undocumented mothers or mothers subject to the five-year bar are entitled to a full year of deemed newborn eligibility to the same extent as children born to citizen or qualified alien mothers not subject to the five year bar. We urge the Secretary to correct this misstatement of federal law in the preamble.

complications, require critical, more costly interventions. Prohibiting states from granting coverage until documentation of citizenship is provided places hospitals and physicians treating newborns at risk for a delay in, or denial of, reimbursement and needlessly jeopardizes the health of these babies.

We strongly urge that the Secretary amend 42 CFR 435.407(a) by adding a new subparagraph (6) to state:

> (6) A record of payment for the birth of the individual, including electronic claims records, by any of the following entities: the State Medicaid agency; the agency which administers a separate child health program under Subchapter D, Part 457 of this title; or a managed care organization which administers the benefits covered under the State's Medicaid and/or separate child health program.

2. *Native Americans should be able to use a tribal enrollment card issued by a federally-recognized tribe to meet the documentation requirements (Primary Evidence of Citizenship, 42 CFR 435.407(a))*

While the interim regulations, at 42 C.F.R. 437.407(e)(6), recognize Native American tribal documents as proof of identity, the regulations do not permit tribal enrollment cards to be used as evidence of citizenship. (The regulations only allow identification cards issued by DHS to the Texas Band of Kickapoos to serve as secondary evidence of citizenship and census records for the Seneca and Navajo Nations as fourth-level evidence of citizenship).

Over 560 tribes in 34 states 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. Tribal genealogy charts date back to original and historic tribal membership rolls, and each Federally-recognized tribe is responsible for issuing tribal enrollment cards to its members. These cards are used in establishing eligibility for Federal benefits as well as tribal resources and voting in tribal matters. In short, tribal enrollment cards are highly reliable evidence of U.S. citizenship.

Further, 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. The exception would be a Federally-recognized tribe located in a state that borders Canada or Mexico and which issues tribal enrollment cards to non-U.S. citizens. In such cases, the Secretary could require additional documentation of U.S. citizenship and tribal enrollment cards would qualify as evidence of identity but not citizenship.

If tribal enrollment cards are not recognized as proof of citizenship, American Indians and Alaskan Natives (AI/AN) might not be able to produce a birth certificate or other satisfactory proof of citizenship. Many traditional AI/ANs were not born in a hospital and there is no record of their birth, except through tribal genealogy records. Thus, failure to recognize tribal enrollment cards as proof of citizenship creates an unnecessary barrier to AI/AN participation in the Medicaid program. Accordingly, we strongly urge the Secretary to revise the regulation by adding a new paragraph (7) at 42 CFR 435.407(a) to read:

(7) A Tribal enrollment card, issued by a Federally-recognized tribe, unless the tribe is located in a state that borders Canada or Mexico and issues tribal enrollment cards to non-U.S. citizens.

3. *Proof of naturalized citizenship for parent should be accepted as primary evidence of citizenship for foreign-born children (Secondary Evidence of Citizenship, 42 CFR 435.407(b))*

Foreign-born children gain "derivative" U.S. citizenship when one of their parents becomes a naturalized citizen. However, such children do not routinely receive a Certificate of Naturalization or other document proving their citizenship. Getting the proper paperwok (e.g., a passport or Certificate of Citizenship) can be a time-consuming and expensive process, which, at a minimum, will delay receipt of Medicaid for some eligible children and, at worst, may result in others never getting coverage. This result is unnecessary, since proof of the parent's naturalized status conclusively establishes the child's citizenship. Therefore, we urge the Secretary to add a paragraph (12) to section 435.407(b) to read:

(11) *Certificate of Naturalization (DHS Forms N-550 or N-570).* The Department of Homeland Security issues these forms. While a certificate of naturalization serves as primary evidence of citizenship for the individual to whom the certificate is issued, such certificate also provides secondary evidence of citizenship for the foreign-born children (including adopted children) of the parent to whom such certificate is issued.

4. *The Secretary should adopt the approach taken by the Supplemental Security Income program for U.S. citizens who otherwise lack documentation of their citizenship (Fourth Level of Evidence of Citizenship, 42 CFR 435.407(d))*

There inevitably are and will continue to be 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 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 interim rule, such individuals, if they apply for Medicaid, can never qualify. Those who are currently receiving Medicaid will eventually lose their coverage, even though they are U.S. citizens and otherwise eligible for Medicaid.

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.

The reality is that there are significant numbers of U.S. citizens who simply will not be able to provide documentary evidence of citizenship at any level provided for in the interim final rule. Unable to do so, these individuals will be denied (or, if currently receiving Medicaid, ultimately will lose) coverage and access to critical services. Their health may suffer, and the burden on hospital emergency rooms and other providers of uncompensated care will grow.

This result is both foreseeable and unnecessary. 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 are capable of reliably determining 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 generally accepted 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 State Department also provides more flexible options to document citizenship in issuing U.S. passports.) The Secretary should adopt a similar approach. Specifically, 42 CFR 435.407 should be revised by adding a new subparagraph (6) to subsection 435.407(d) to provide:

> (6) In the case of an individual who is unable to produce any of the documentary evidence described in subsections (a) through (d), the state Medicaid agency, at its option, may determine that the individual is a U.S. citizen for purposes of receiving Federal financial participation under section 435.1008 if the individual or his or her guardian or other authorized representative—
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> (i) Explains why none of the documentary evidence described in subsections (a) through (d) is available; and
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> (ii) Provides any information he or she does have which shows that the individual was born in the United States or that the individual has voted in the United States (in an election requiring U.S. citizenship) or that otherwise indicates U.S. citizenship; and
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> The agency finds that 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.

Insofar as the regulations permit evidence of citizenship approved by SSI to count as proof of citizenship in Medicaid, we do not see why a similar, more flexible documentation approach cannot be permitted for Medicaid applicants and beneficiaries who are not also receiving SSI.

5. *The Secretary should expand the permissible use of affidavits to establish identity (42 CFR 435.407(f) and 435.407(g))*

The DRA provides that identity can be established by "[a]ny identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act." Under 42 CFR 435.407(f) of the interim final regulations, children under the age of 16 can establish identity through a sworn affidavit signed by the child's parent or guardian. Consistent with 8 CFR 274a.2(b)(1)(v)(B)(3) and (4), which implement §274A(b)(1)(D) of the Immigration and

Nationality Act, the Secretary should extend the permissible use of affidavits to children under age 18 and disabled individuals. Specifically, we recommend that section 435.407(f) be amended as follows:

- Insert "and disabled individuals" after "Special identify rules for children" in the heading;
- Replace "children under 16" with "children under 18"; and
- Strike "If" in the second sentence and replace with "For children under 18 and disabled individuals, if".

Section I. Background, *Implementation Conditions/ Considerations* and Section III. Collection of Information Requirements (42 CFR 435.407(h))

The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet, the Secretary has added this as a requirement in the interim final regulations at 42 CFR 435.407(h)(1). We see several fundamental problems with this requirement.

First, requiring that individuals obtain and submit originals or certified copies will exacerbate the information-collection burden imposed by the regulations on applicants, beneficiaries and state Medicaid agencies, and calls into question the estimate that it will take applicants and beneficiaries only ten minutes and state agencies five minutes to comply. In addition to the time spent in locating and/or obtaining original or certified copies of documents, applicants and beneficiaries likely will have to visit state offices to submit them, as they often undoubtedly will be reluctant to mail an original. As noted above, there are approximately 38 million current beneficiaries who may be affected by the interim rule and an estimated 10 million new citizen applicants who will be required to prove their citizenship over the course of the next year. For each, the state Medicaid agency will have to meet with the individual or his/her representative, make a copy of the pertinent documents, maintain the records and, in some instances, provide assistance in obtaining an original or certified copy.

Second, requiring original or certified copies also will undermine the effort many states have made to simplify the application process – simplifications which have increased the accessibility of Medicaid for many eligible low-income families and children and other individuals. To the extent possible, for example, many states routinely obtain verification of various eligibility requirements from other state or federal agencies; indeed, as part of the eligibility redetermination process, states are required to do so. Child welfare agencies, for example, likely will have a copy of a foster child's birth certificate or other documentation of citizenship, obtained in verifying eligibility for foster care benefits. Yet, section 435.407(h)(1) of the interim final regulation precludes states from obtaining a copy of probative documentation from another agency, even if that agency itself had received an original or certified copy.

Moreover, many applicants and beneficiaries will find obtaining an original or certified copy difficult, if not prohibitive. And many more will be understandably reluctant to mail original birth certificates, passports or other such documents, or their only certified copy. They certainly will not be able or willing to mail in proof of identity, such as a driver's license or school identification card. The result will be that applicants and beneficiaries will have to make

otherwise unnecessary visits to state or county Medicaid offices. Those who cannot afford to miss work, lack transportation, are not mobile or otherwise are unable to travel to the Medicaid office during business hours will forego the application process altogether, thereby never receiving the coverage they and their families need. The inevitable result will be that eligibility determinations will be delayed and/or ultimately denied, and that health care providers will experience delays in reimbursement and increased uncompensated care.

We are not aware of any reliable research that demonstrates that undocumented immigrants are obtaining non-emergency Medicaid services by falsely claiming citizenship.[9] Nonetheless, in order to alleviate any concern that accepting copies of documents could result in undocumented immigrants becoming eligible for full Medicaid benefits, the Secretary should require that states opting to accept copies of documents must implement effective, fair and non-discriminatory procedures to ensure the integrity of the application process. For example, a state could institute a system to randomly check the original or certified documents of some applicants and beneficiaries. The State would need to terminate the eligibility of anyone found to have submitted fraudulent copies and, if the percentage of fraudulent copies was found to be unacceptable, the Secretary could require the State to take appropriate remedial measures – including, if necessary, requiring original or certified copies from all applicants and beneficiaries.

Accordingly, we urge the Secretary to revise the regulation by modifying subparagraph (1) of 42 CFR 435.407(h) as follows:

> (1) All documents must be either originals or copies certified by the issuing agency or entity, except that, at their option, States may accept copies of documents provided that the State —
>
> (i) Requires submission of an original document if the State has a reasonable suspicion that the copy is counterfeit, has been altered, or is inconsistent with information previously supplied by the applicant or beneficiary; and
>
> (ii) Has implemented effective, fair and non-discriminatory procedures for ensuring the integrity of the application process.

COMMENTS ON CHANGES MADE TO REGULATIONS GOVERNING IMMIGRANT ELIGIBILITY

With the passage of PRWORA, Congress changed the rules for Medicaid eligibility of immigrants residing in the United States. For the most part, to be eligible for full Medicaid benefits, an immigrant must fall into the definition of a "qualified alien" set forth in section 431 of PRWORA, as amended, 42 USC 1641. However, several groups of legal immigrants who are eligible for full Medicaid benefits are not included in the definition of "qualified alien."[10] In limiting eligibility of

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[9] Similarly, in CMS' response to the Office of Inspector General (IOG) Draft Report: "Self-Declaration of U.S. Citizenship for Medicaid" (OEI-02-03-00190), the CMS Administrator noted: "The [OIG] review found that, while there are vulnerabilities in states' accepting self-declaration of citizenship, states have little evidence that many non-eligible, non-citizens are receiving Medicaid as a result." See memo dated April 8, 2005 from Mark B. McClellan to Daniel R. Levinson, attached at Appendix D to the final OIG report.

[10] The following immigrants are not included in the definition of "qualified alien" in section 431 of PRWORA, but are eligible for Medicaid:

legal immigrants for Medicaid to those who fall into the definition of "qualified alien" under section 431 of PRWORA, the interim final regulation at 42 CFR 435.406(a)(2) fails to recognize the eligibility of these other groups of legal immigrants.[11]

In addition, 42 CFR 435.406(a)(2) of the interim final regulation would limit Medicaid benefits to legal immigrants whose immigration status has been verified with the Department of Homeland Security. We have two comments on this aspect of the regulation. First, as is the case with verification of U.S. citizenship, verification of immigration status is not a criterion of Medicaid eligibility. Indeed, section 1137(d)(4)(A) of the Act expressly requires states to provide benefits to otherwise eligible individuals who have declared to be in a satisfactory immigration status, pending verification of such status. Therefore, we recommend that the regulatory provisions governing eligibility based on citizenship and immigration status be separated from those governing verification.

Second, the interim final regulation would require the immigration status of all legal immigrants to be verified with DHS. However, the status of some immigrants eligible for Medicaid cannot be verified with DHS. Such immigrants include, for example, victims of a severe form of trafficking, whose status must be confirmed with the Office of Refugee Resettlement, and certain American Indians, the status of some of whom must be confirmed through tribal documents.

Accordingly, we recommend that the Secretary modify the regulations at 42 CFR 435.406 as follows:

1. Delete subparagraphs (ii) and (iv) of 42 CFR 435.406(a)(1).
2. Revise 42 CFR 435.406(a)(2) to read:

§435.406(a) * * *

(2) Individuals who declare, under section 1137(d) of the Act, to be
(i) A qualified alien as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), as amended, 8 U.S.C. 1641;

- Victims of a severe form of trafficking and certain of their family members – In accordance with section 107(b)(1)(A) of the Trafficking Victims Protection Act, 22 USC 7105(b)(1)(A), trafficking victims are eligible for means-tested benefits, including Medicaid, to the same extent as refugees (who are included in the definition of "qualified alien"); subsequent legislation also extended eligibility for such benefits to family members of trafficking victims who hold a so-called "Derivative T Visa." See 22 USC 7105(b)(1).
- Certain American Indians born outside of the United States – Under section 402(b)(2)(E) of PRWORA, as amended, there are two groups of American Indians who, although not U.S. citizens and not included in the definition of "qualified alien," are eligible for full Medicaid benefits: (1) American Indians born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply and (2) members of a Federally-recognized tribe, as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act, 25 USC 450b(e).
- Non-qualified aliens receiving SSI – Section 402(b)(2)(F) of PRWORA, as amended, grandfathered the Medicaid eligibility of non-qualified aliens receiving SSI as of the date PRWORA was enacted (August 22, 1996)

[11] The definition of "qualified alien" also was amended by legislation enacted after PRWORA. We also recommend that this be acknowledged in the text of the regulation.

(ii) A victim of a severe form of trafficking, or a family member of such a victim who holds a Derivative T Visa, as provided under 22 USC 7105(b)(1);
(iii) An American Indian described in §402(a)(2)(G) of PRWORA, as amended, 8 USC 1612(a)(2)(G); or
(iv) Receiving Supplementary Security Income Program benefits, as provided in §402(b)(2)(F) of PRWORA, as amended, 8 USC 1612(b)(2)(F).

3. Add a new paragraph (b) to 42 CFR 435.406 to read:

(b) The State Medicaid agency must —
(i) Effective July 1, 2006, for individuals declaring citizenship or national status, verify such status at initial application or redetermination, in accordance with the procedures set forth in §435.407;
(ii) For individuals declaring to be in satisfactory immigration status, the State Medicaid agency shall –
(I) Verify such status with the Department of Homeland Security (DHS), in accordance with the procedures set forth in section 1137(d)(4) of the Act, or through other such means where appropriate.
(ii) Pending completion of such verification procedures, not delay, deny, reduce, or terminate the individual's eligibility for benefits.

Again, thank you for the opportunity to comment on this interim regulation. If you have any questions, please do not hesitate to contact Sarah deLone at 202-408-1080.

Sincerely,

Robert Greenstein
Executive Director

Sarah deLone
Senior Policy Analyst

NACBH

NATIONAL ASSOCIATION FOR CHILDREN'S BEHAVIORAL HEALTH

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AUG 11 2006

August 11, 2006

Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Room 445-G
Hubert Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 21244-1850

Re: Interim Final Rule with Comment Period: Citizenship Documentation Requirements

The National Association for Children's Behavioral Health (NACBH) appreciates the opportunity to comment on the interim final rule on citizenship documentation requirements published in the July 12 Federal Register implementing section 6036 of the Deficit Reduction Act of 2005.

NACBH is a non-profit trade association representing multi-service treatment and social service agencies proving a wide array of behavioral health and related services to children, youth, and their families. Services provided by NACBH members include assessment, crisis intervention, residential treatment, group homes, family-based treatment homes, foster care, independent living, alternative educational services, in-home treatment, outpatient counseling and a plethora of community-based and outreach programs. Providers serve clients from the mental health, social service, welfare, juvenile justice and education systems. We can say with surety that 99% of our membership serves Medicaid recipients. It is for this reason that we can also say with surety that this regulation, as proposed, will prove overly burdensome and difficult for the children and families our members serve, potentially having the unintended consequence of delaying needed care and attention. While we have numerous concerns with the rule, we are limiting are comments to those issues of most concern to us.

We commend the Department for recognizing the need to broaden the categories of allowable documents to be used. The use of the State Data Exchange and vital records databases to cross-match citizenship records is a help for states. We also appreciate the solicitation for comments and suggestions for the use of other electronic data matches with government systems of records. This, however, does not help defer the immediate crises caused by the very restrictive list of documents acceptable under the rule.

435.407 Types of acceptable documentary evidence of citizenship

CMS has asked for comments regarding whether the documentation that can be used to prove citizenship should be limited to only Tier 1 or 2. We strongly urge CMS not to limit the types of documents that can be used to validate citizenship status. Most

Medicaid applicants and recipients will not have passports or the financial means to obtain one. Birth certificates may also be difficult for those who may have been born at home or do not have access to a birth certificate due to a natural disaster. For these persons, we urge CMS to add that a state Medicaid agency's record for payment for the birth of an individual in a U.S. hospital is primary documentary evidence of both citizenship and identity.

435.407(h) Documentary evidence

Copies of documents should be sufficient proof of citizenship. The new rule requires that individuals submit original documents (or copies certified by the issuing agency) to satisfy the citizenship and identity requirements. This provision poses a significant burden for both the individual and the state agency. Over the years, many states have simplified and streamlined the application procedures for Medicaid, adopting a mail-in application process. This has allowed greater efficiencies while increasing legitimate participation in the program. While in the preamble CMS clarifies that the documentation requirement does not prohibit utilization of mail-in applications and renewal processes, the requirement that individuals submit original documents undermines these efforts. If they are even available, it is highly unlikely that individuals will want to mail in their original documents and rely on the Medicaid agency to return them in a timely manner. Furthermore, it is impractical for someone to mail in a driver's license which they need on a daily basis. This provision is unreasonable and will delay coverage for new applicants who are forced to schedule face-to-face appointments, and may even discourage them from applying. Nothing in the DRA requires Medicaid applicants or recipients to submit original or certified copies to the Medicaid agency in order to fulfill this new documentation requirement. We urge CMS to eliminate this requirement.

435.407(j) Reasonable opportunity to present satisfactory documentary evidence of citizenship

Medicaid coverage should not be delayed because of lack of citizenship documentation. While we commend CMS for requiring states to provide a "reasonable opportunity" to submit documentation to those applying for or renewing Medicaid coverage, we are concerned that the rule is more stringent than required by the law by not allowing people who are applying for and who are eligible for Medicaid to be enrolled until they have submitted satisfactory evidence of their citizenship status. This interpretation will cause significant delays in access to health care services for many.

Permitting those already on the program to remain eligible while documentation is gathered while not applying the same rule to those applying for the first time is arbitrary and discriminatory. There is no statutory requirement to prohibit people eligible for Medicaid from enrolling in the program immediately. As written, the citizenship documentation requirement is a requirement for states to receive federal matching funds, not an eligibility requirement for individuals. Once a person declares under penalty of perjury that they are an American citizen and meet all of the eligibility requirements, they should be enrolled in the program pending the submission of all the appropriate documentation.

435.407(k) Proposed new section

CMS should include a safety net for those who cannot prove citizenship. Despite the many avenues for obtaining citizenship and identity documentation provided in the rule, many Medicaid applicants and recipients who are US citizens will not be able to come up with the kinds of documentation CMS has

determined to be appropriate. The homeless, victims of natural disasters, individuals who have special health care needs or those with a severe mental illness top our list of those most adversely affected. Although the rule directs the states to assist "special populations" with finding documentation, the rule also states that if none are found, states may deny or terminate coverage. Undoubtedly, US citizens who are eligible will be denied or lose coverage. If an SSI applicant cannot produce one of the required documents that indicates US citizenship, they may explain why they cannot provide any of these documents and instead provide information they do have as alternative proof. We urge CMS to adopt the rules applied to the SSI program, adding a new provision at 42 CFR 435.407(k).

435.1008 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

We do hope the omission of children receiving Title IV-E foster care assistance from the list of excluded individuals was an error. Foster children must document citizenship to receive IV-E funding. Children who receive IV-E foster care payments are categorically eligible for Medicaid and technically do not have to apply for Medicaid. As such these children should be exempt from the Medicaid citizenship documentation requirements, similarly to individuals who receive SSI who have also documented their citizenship and are automatically eligible for Medicaid, a group which CMS has exempted from this rule.

Furthermore, some children entering foster care come from homes where parents have been charged with abuse or neglect, making it unlikely to impossible to be able to obtain the necessary documentation. Parents may be unwilling to cooperate with any state agency or their whereabouts may be unknown. Other children enter foster care because of special health and mental health care needs which require immediate and ongoing attention. Delaying care while documentation is sought would be devastating to the treatment and long term interests of the child. We, therefore, urge CMS to add an exemption for IV-E foster children.

We are pleased to add our comments to the many you have received. This is an issue of vital importance to the millions of children, pregnant women, and parents who will be applying for Medicaid benefits and to the states who must be able to continue to provide them with coverage. This rule must not result in cost-shifting, ultimately forcing millions to drop or be dropped from coverage.

Thank you.

Cordially,

Joy Midman
Executive Director

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NASMHPD National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302, Alexandria VA 22314 (703) 739-9333 Fax (703) 548-9517

AUG 11 2006

August 11, 2006

Mark B. McClellan, M.D., Ph.D.
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: CMS-2257-IFC

Dear Dr. McClellan:

On behalf of the National Association of the State Mental Health Program Directors (NASMHPD), thank you for the opportunity to comment on the Interim Final Rule regarding Citizenship Documentation Requirements.

NASMHPD represents the $26 billion public mental health systems that serve 6.1 million people in 50 states, four territories, and the District of Columbia. As the directors of the state mental health systems, our members administer and manage a full range of inpatient and community-based systems of care for the millions of individuals with mental illness.

Medicaid is one the most importance financing streams for mental health services. It provides more than half of the resources for state and local community mental health services, making it the primary funding source of public mental health system services for low-income people with mental disorders. Medicaid is also an important source of coverage for mental health services for adults and children who turn to the public mental health system for their care, for children in care of child welfare systems and for low-income individuals who require treatment of mild and moderate mental disorders. Without Medicaid, the most vulnerable individuals with mental illness would not have access to the vital care on which they rely.

NASMHPD applauds the Centers for Medicare and Medicaid Services (CMS) for the many positive changes made in the Interim Final Rule that benefit individuals with mental illnesses. While these are very helpful provisions, NASMHPD would like to offer the following comments and

suggestions to ensure that individuals with mental illness have uninterrupted access to the services and medications that significantly improve their health and their lives.

Exemptions for Specific Populations

NASMHPD commends CMS for ameliorating the impact of the new documentation requirement by recognizing the "scrivener's error" in the statute and exempting individuals on Supplemental Security Income (SSI) or Medicare from the new rule. However, exemptions should also be provided for other individuals who have already proven their citizenship, such as foster children who are eligible for Title IV-E funds and individuals on Social Security Disability Insurance (SSDI) who are in the waiting period for Medicare or disability payments.

Special Populations Needing Assistance

NASMHPD appreciates CMS' acknowledgement of the challenges faced by individuals with a cognitive, mental, physical, or sensory disability in locating documentary evidence in a timely manner. However, we recommend clarifying the term referring to those with "incapacity of mind or body" as individuals who, "due to a physical or mental condition" are unable to comply with the requirements to present satisfactory documentary evidence. Assistance should also be extended to individuals who are homeless and those who have lost their identifying documents in a disaster.

Determining Eligibility

NASMHPD is concerned that CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates. Under the Deficit Reduction Act of 2005 (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." Therefore, NASMHPD recommends that once an applicant for Medicaid declares she or he is a citizen and meets all eligibility requirements, eligibility should be granted.

Data Matching

NASMHPD appreciates CMS' recognition of the valuable role that the Social Security Administration's State Data Exchange database (SDX) and state vital records databases may play as states cross-match citizenship records. We are pleased that states may now also use some additional state and federal databases to conduct identity cross-matches. However, NASMHPD recommends that data systems maintained by the state mental health agencies also be among the state data systems with which a match may be made. We also suggest that CMS provide additional information on acceptable data sources.

Interstate Transfer of Information

Individuals with serious mental illnesses are often transient and change providers frequently. For this reason, NASMHPD requests that CMS clarify that once applicants or recipients have met the documentation requirement in one state, they will not be required to demonstrate citizenship again for Medicaid enrollment if they move to another state.

Native Americans

Although the Interim Final Rule recognizes Native American tribal documents as proof of identity, it does not permit tribal enrollment cards to be used as evidence of citizenship. NASMHPD urges CMS to recognize that a significant number of Native American children and adults are in great need of health care and mental health services. We strongly recommend that CMS revise the regulation at 42 CFR 435.407(a) to specify that a tribal enrollment card issued by a federally-recognized tribe be treated like a passport and deemed primary evidence of citizenship and identity.

Again, please accept our appreciation for your time and attention to these important issues. Should you wish to discuss our comments further, please do not hesitate to contact me at (703) 739-9333.

Sincerely,

Robert W. Glover, Ph.D.
Executive Director

cc: Eric Broderick, D.D.S.
A. Kathryn Power, M.Ed.

Chamberlin Edmonds
Healthcare Revenue Recovery Specialists

August 10, 2006

Mark McClellan, M.D., Ph.D., Administrator
Centers for Medicare & Medicaid Services
Dep't of Health & Human Services
Attention: CMS-2257-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Office of Information & Regulatory Affairs
Office of Management & Budget
Room 10235, New Executive Office Building
Washington, DC 20503
Attention: Katherine T. Astrich, CMS Desk Officer, CMS-2257-IFC

RE: Medicaid Program; Citizenship Documentation Requirements (CMS-2257-IFC)

Dear Dr. McClellan,

Chamberlin Edmonds is a private company engaged by hospitals to assist patients with application for public programs. The company was founded in 1986 and currently provides services in twenty five states. Headquartered in Atlanta, Georgia, Chamberlin Edmonds provides regional coverage through district offices in Orlando FL, Albany GA, Ashland KY, Detroit MI, Union NJ, Charlotte NC, Cleveland OH, Dallas TX, and Hampton VA.

We currently assist our clients with a variety of Medicaid benefits applications. We also provide medical evidence from hospital records, help clients to obtain evidence and remind them to keep appointments, if not also providing transportation to appointments. We also function as liaison for the client in sending proper documentation to state Medicaid agencies.

Thank you for the opportunity to comment on this interim final rule published on July 12, 2006, regarding citizenship documentation requirements for Medicaid. We support CMS' decision not to require SSI recipients and Medicare eligibles to follow these requirements. However, we are concerned that CMS has proposed hurdles above and beyond statutory requirements and has dramatically underestimated the amount of time required to comply with these requirements for the rest of the Medicaid population, especially those who are homeless, victims of natural disaster, or not born in a hospital.

I. Introduction: Survey Results

In late June, in connection with the National Association of Public Hospitals, we performed a one-week survey of all the patients we screened (except those who are not affected by the legislation) to determine the likely impact of these regulations. 980 patients were surveyed over the week of June 27 to July 3, representing over 200 hospitals in 25 states.

Our results showed that 51.1% of patients surveyed could not prove citizenship. These patients all claimed to U.S. citizens, with no discernible evidence to the contrary.

- 9.4% of patients surveyed could verify citizenship with one of the primary documents.
    - 78.3% of those could produce the document within one week, representing 7.3% of the total survey population.
- 39.5% of patients surveyed could verify citizenship through a combination of secondary through fourth-level documents and identity documentation.
    - 66.1% of those could produce the document within one week, representing 26.1% of the total survey population.

II. §435.407(a) – (c): Types of Acceptable Documentary Evidence of Citizenship

We recognize that CMS' discretion is limited by statute; however, we would note that very few prospective Medicaid beneficiaries have or have had passports. Therefore, for most of our clients, we will be attempting to prove citizenship through a combination of birth records and identification. Many individuals who are born into impoverished families do not have access to a birth certificate. A birth certificate may not have been created if the individual was not born in a hospital. Those cases will require contacting the vital statistics agency of the state in which the individual says that s/he was born to see if there is a birth record.

There are significant hurdles to access to birth records or birth certificates. In some cases, only the individual named on the birth record is able to obtain the record (Alaska), or other individuals may obtain it but not a non-attorney representative (California, Connecticut, Texas, and Wyoming). Some states require that the application be notarized (California and Minnesota), which poses an additional cost to the applicant, or that it be accompanied by government-issued photo identification that many individuals will not have (Connecticut, Delaware, Florida,

Georgia, Indiana, Iowa, Louisiana, Montana, Nebraska, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, and Texas).

On-line services generally require prepayment by credit card, and sometimes require that the credit card holder be the same individual named on the birth record. Many prospective Medicaid beneficiaries do not have credit cards. The applicant must go to the vital statistics office to request the birth record themselves, but that process is difficult for an aged, sick and/or financially needy individual.

Many times a client is not sure, does not accurately remember, or was given inaccurate information about the state in which s/he was born. Additional research is available from some state agencies, but generally at added cost. Additionally, for newborns, there will be a time lag while the official documents are created.

We suggest that CMS modify §435.407(b)(1) to read that a State **must** first attempt a cross match with a State vital statistics agency **at no cost to the applicant** to document a birth record.

With respect to the third- and fourth-level documents listed in §435.407(c) and §435.407(d), we ask CMS to consider adding language that would give States flexibility when documents are presented that were created less than five years before the application date. The law as enacted does not mention a five-year requirement, but rather allows the Secretary to specify documents that provide proof of U.S. citizenship or nationality. Individual caseworkers should be allowed the discretion to evaluate whether a hospital record created at birth, life insurance, tribal documents, physician or midwife statements, or medical records created less than five years before application provide adequate proof of citizenship.

Similarly, with respect to the written affidavits described in §435.407(d)(5), we urge you to consider delegating some discretion to caseworkers who would be evaluating whether the affidavits are probative of citizenship. The process laid out in this section essentially requires that an individual obtain three affidavits, one from the individual or other person attesting to why other documents are not available and two from other individuals attesting to the applicant's citizenship and identity. Requiring that every affiant be able to provide his or her own citizenship and identity may entail additional affidavits, resulting in an onerous process for the applicant. If the State had some measure of flexibility in accepting these affidavits, fewer citizens would be excluded from eligibility.

III. §435.407(g): Special Populations Needing Assistance

We recommend that CMS expand the definition of special populations needing assistance to include homeless individuals, victims of natural disaster, and people not born in a hospital. We reiterate our request that CMS require the states to provide this assistance among other things, by running data matches with state vital statistics agencies at no cost to the applicant.

IV. §435.407(h)(1): Original documents

We also request that CMS consider accepting photocopies of documents as opposed to requiring that the documents be presented in either original or certified form. Those individuals who have original documents will be loath to mail them to a state agency out of fear that they will be lost, not returned, or exploited for identity theft. If an applicant does not want to risk mailing, the only option would be to bring the documentation to the agency office, rendering dysfunctional the provision at §435.407(h)(3) not to require an interview. The provision requiring original documents is not part of the law as originally passed by Congress and is therefore within CMS' discretion. Including it in the final regulation will impose a barrier to access to medical benefits for bona fide citizens.

V. §435.407(j): Reasonable Opportunity

Our survey results show that complying with these requirements will take one-third of our client population who believe that they can obtain the documents more than seven days to do so, far surpassing the agency's estimation of ten minutes. Given the involved processes described under Section II above regarding obtaining birth records, we believe that complying with the regulation will take significantly longer than ten minutes. This contingency is important because it bears on the question of what constitutes a "reasonable opportunity" to present the required documents before a case has to be denied. It is possible that it would take an individual forty five days or more to obtain the required documents to prove citizenship. Although a state agency is required by §435.911(a)(2) to make an eligibility decision within forty five days in many cases, that regulation also prohibits the agency from making a denial simply due to timely decision-making requirements (42 CFR 435.911(e)(2)). We ask CMS to consider a provisional eligibility category that would enable an applicant to receive benefits if they have shown a good faith effort to obtain the required documents but have been unable to do so due to circumstances beyond their control.

VI. Collection of Information Requirements

Based upon our survey described in Section I above and our research regarding obtaining birth records described in Section II above, we believe that it would take an individual considerably longer than ten minutes to acquire and provide to the State acceptable documentary evidence of citizenship and identity. We estimate that it will take many individuals longer than seven days to acquire this evidence and is likely to exceed forty-five days if additional research and requests to other states are required.

Understandably, CMS was statutorily limited to promulgation of regulations pursuant to the law that Congress enacted. However, CMS need not promulgate regulations that are stricter than what was enacted, and we urge you to grant the states a measure of discretion whenever possible in this process.

It is not in the best interests of medically needy Americans to deny benefits based on an inability to produce difficult to access documents. Further, this is not in the best interests of states, local governments or the hospital community. Indigent sick and injured people will receive care. These provisions will deprive the providers of that care of necessary financial support. The

impact of these interim regulations will be felt principally by needy Americans and the health care facilities that provide their care. Thank you for your kind attention.

Respectfully submitted,

Judith E. Starkey /EA. McGown

Judith E. Starkey
Chief Executive Officer

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CHRISTINE O. GREGOIRE
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August 8, 2006

Dr. Mark B. McClellan, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2257-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator McClellan:

I am submitting this comment letter on the Medicaid citizenship documentation requirements included in Section 6036 of the 2005 Deficit Reduction Act signed by President Bush on February 8, 2006. Specifically, this letter concerns the Interim Final Rule published July 12, 2006, in the Federal Register (71 FR 39214) for the Centers for Medicare and Medicaid Services (CMS).

On June 26, 2006, I sent a letter to Secretary Michael Leavitt with my concerns about the new law and CMS' subsequent guidance issued in a June 9, 2006, letter to state Medicaid Directors. I raised primary concerns with respect to particular populations and the negative impact the guidance has on the ability of seniors, foster children, and federally-recognized tribes, especially, to access Medicaid, as well as the archaic methodologies to prove citizenship that disallow the use of document copies or information technology to transmit vital statistical data. While I am pleased to see that the Interim Final Rule, as promulgated, meets some of the needs expressed in my earlier letter, it still leaves out a number of other concerns that, if not corrected, will have detrimental impacts on individuals who are otherwise fully eligible for Medicaid services.

To the credit of the Department of Health and Human Services and CMS, the Interim Final Rule does: (1) recognize that individuals on SSI or Medicare are exempt from the new rule; (2) allow the use of the State Data Exchange (SDX) and state vital records databases to cross-match citizenship records, and allow states to use state and federal databases for identity cross-matching; and (3) clarify that the new citizenship documentation requirement does not apply to "presumptive eligibility" for pregnant women and children on Medicaid, so states may continue to use this effective and important strategy for enrollment. However, several aspects of the rule remain problematic and overly burdensome for other Medicaid recipients and applicants, including American Indians/Alaska Natives, and continue to place a significant burden on the states.

I respectfully ask that the following items be taken into consideration, and that suggested corrective measures be taken into account in the final rule:

- Medicaid Payment for Births as Proof of Citizenship and Identity. There is no question that an infant born in a U.S. hospital is a U.S. citizen. As such, a state Medicaid agency's record of payment for the birth should serve as primary, documentary evidence of both citizenship and identity. The Interim Final Rule does not currently recognize the record of payment as proof. I, therefore, request this change in the final rule.

- Foster Children. Foster children must already document citizenship to receive Title IV-E assistance, much like SSI or Medicare recipients must document their citizenship for these programs. Having explicitly exempted SSI and Medicare recipients from the citizenship documentation requirement, CMS should exempt foster children, as well. I request that this change be included in the final rule. In the alternative, and at the very least, I ask that CMS commit to treating this foster child population – through rule – as "recipients" of Medicaid rather than "applicants." To do so would be consistent with verbal comments made by CMS staff to State Medicaid Directors that CMS would treat this population as such.

- Federally Recognized Tribes. There are twenty-nine federally-recognized tribal nations in Washington State. As I pressed in my June 26 letter, the guidance and the Interim Final Rule do not allow Native American tribal identification cards to be used to prove U.S. citizenship, yet they may be used for identity purposes. These cards, issued by the federal Bureau of Indian Affairs, actually read that they are proof of U.S. citizenship. Especially because some tribal members may not have been born in hospitals and, therefore, have no official record of their birth, I most emphatically urge CMS to allow tribal identification cards to be used as primary documentary evidence of both an individual's U.S. citizenship and identity in the final rule.

- Current Medicaid Beneficiaries and Applicants, Alike, Should Have Reasonable Opportunity to Provide Necessary Proof of Citizenship. As I discussed in my June 26 letter, I appreciate that CMS – through its guidance and proposed rule – gives those individuals who are currently receiving Medicaid a "reasonable opportunity to submit satisfactory documentary evidence of citizenship before taking action affecting the individual's eligibility for Medicaid." Contrast this treatment of current beneficiaries to new applicants who are not given a similar, reasonable opportunity to be made eligible until they present the required evidence.

  I am concerned that, as promulgated, the proposed rule goes further than what is required by Section 6036 of the DRA and that CMS's current interpretation of the statute will cause significant delays in health care coverage for many vulnerable people who are otherwise eligible for Medicaid. I urge CMS to revise the rule so that applicants who declare they are U.S. citizens and meet all of the Medicaid eligibility criteria can be enrolled in Medicaid while they have a reasonable opportunity period to obtain the documentation necessary to prove their U.S. citizenship and identity, just as current enrollees do.

- Copies of Documents. To satisfy the citizenship and identity requirements, the new rule requires that individuals submit original documents or copies certified by the issuing agency. This provision poses a significant burden for both individuals and state agencies. I ask that the final rule recognize the importance of allowing the use of document copies.

Over the years, many states, Washington among them, have simplified and streamlined application procedures for Medicaid with changes that include adopting a mail-in application process and eliminating face-to-face interviews. These processes reduce Medicaid administrative costs and make the program more effective by increasing participation among those eligible for Medicaid services.

In the Interim Final Rule, CMS attempts to clarify that the documentation requirement does not prohibit utilization of mail-in application and renewal processes; however, the requirement that individuals submit original documents simply undermines these efforts. It is highly unlikely that individuals will want to mail in original documents such as a birth certificate or certificate of naturalization or citizenship, relying on the Medicaid agency to return them. Furthermore, it is impractical for someone to mail in a driver's license to document their identity for Medicaid purposes and, in doing so, would certainly result in additional problems. This provision of the rule delays coverage for new applicants who must schedule appointments with the Medicaid agency to fulfill this requirement and may even discourage some applicants from completing the application process altogether.

Because the Deficit Reduction Act does not require Medicaid applicants or recipients to submit original or certified copies to the Medicaid agency to fulfill the new documentation requirement, I request that the requirement for original documents be eliminated in the final rule.

- Citizenship Documentation as Another Unfunded, Federal Mandate. States already bear significant burdens resulting from federal mandates. Requiring states to identify citizenship documentation for Medicaid recipients is an additional, significant one. Washington State's Department of Social and Health Services estimates that 67.9 full time employees (FTEs) will be needed to accomplish this in state Fiscal Year 2007, and 34.1 FTEs in state fiscal year 2008 and beyond. We expect total administrative costs of $4.55 million in state Fiscal Year 2007, and $2.21 million in state Fiscal Year 2008 and beyond.

  I request that CMS give states a higher Federal Medicaid Assistance Percentage (FMAP) to cover the costs of this new responsibility and to help provide for the infrastructure necessary to comply with the new law.

Again, thank you for taking some of my earlier comments on the June 9 guidance into account when promulgating the Interim Final Rule. In order to ensure that those who are eligible for Medicaid, whether as current recipients or new applicants, will not lose or be denied coverage for critical health care benefits, I believe the outstanding issues I have highlighted must also be resolved in the final rule.

Thank you for your consideration of my concerns. If you have any questions, please do not hesitate to contact Mark Rupp, my Health and Human Services Policy Advisor, at (202) 624-3639.

Sincerely,

Christine O. Gregoire
Governor

NATIONAL YAP™
YOUTH ADVOCATE PROGRAM

Marvena Twigg
President/CEO

August 10, 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 Program; Citizenship Documentation Requirements Interim Final Rule

The National Youth Advocate Program, Inc., (NYAP) submits the following comments with regard to the interim rule to implement Section 6036 of the Deficit Reduction Act of 2005 (DRA), published in the Federal Register on July 12, 2006. Section 6036 governs the citizenship documentation requirements as they apply to children in our nation's foster care system. Specifically, NYAP is concerned about the application of the rule to children in foster care ('435.1008), and encourages CMS to add an exemption at 42 CFR 435.1008 for foster children.

NYAP is a non-profit child welfare agency with affiliate programs in six states: Georgia, Illinois, Indiana, Ohio, South Carolina and West Virginia. The majority of services provided by NYAP are in the area of foster care. NYAP's foster care clients are children who have been abused or neglected or found to be dependent by the courts.

It is the position of NYAP that an exemption must be added to 42 CFR 435.1008 for foster children. To apply the citizenship documentation requirement to foster children is unfair, unrealistic and over burdensome. These new requirements to prove U.S. citizenship or nationality and identity will create a critical burden on foster children, foster families, and an already overburdened child welfare system. Furthermore, the new requirements are duplicative in the case of foster children, as according to federal law, foster children already must have documented citizenship to receive Title IV-E assistance. This unnecessarily duplication could result in the delay or denial of needed health care and mental health care to foster children, many of who enter state custody in poor health and all of whom enter custody following disruption of their families. This may result in a shift of funds from other needed services, such as prevention, intervention and support services, further denying these children of the help they most direly need.

NYAP strongly recommends that CMS carefully evaluate the impact of these regulations in light of the compelling health care needs of the foster care population and an exemption at 42 CFR 435.1008 for foster children.

Sincerely,

Marvena Twigg

Marvena Twigg
President and CEO

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August 10, 2006

Dr. Mark McClellan, Administrator, Centers for Medicare and Medicaid Services

Subject: Ease Citizenship Requirements for Medicaid Recipients

Re: CMS—2257—IFC

longbeachhawkeye@hotmail.com
Jon Swailes

The Medicaid program plays a vital role in preventing unintended pregnancies and ensuring women have access to the care they need. Medicaid provides health insurance coverage for one in 10 women of reproductive age and pays for more than one-third of all births in the United States The citizenship documentation requirements erect unnecessary barriers by requiring Medicaid-eligible citizens to produce a birth certificate, passport, or similar documentation. CMS should ensure that new Medicaid applicants receive care while they are making a good faith effort to attain the required documentation. CMS should eliminate the current requirement that Medicaid recipients and applicants submit original or certified documentation. CMS should exempt individuals who receive services under a Medicaid family planning demonstration project from the documentation requirements. Through these programs, millions of individuals who do not meet the requirements for standard Medicaid receive family planning services to help them prevent unintended pregnancies.

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Justice and Economic Security for *all* Coloradans

August 8, 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:

The Colorado Center on Law and Policy ("CCLP") is a Colorado non-profit organization whose mission is to increase access to justice and economic self-sufficiency for lower income Coloradans. CCLP serves as Colorado's unrestricted legal services program, and engages in analysis, advocacy and litigation on issues related to access to public benefits in Colorado. The Colorado Fiscal Policy Institute (COFPI) is a project of CCLP. COFPI engages in advocacy, and provides analysis and information about fiscal issues and policy decisions impacting lower income Coloradans. We write 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 are pleased that the Rule as published contains some significant changes from the earlier SMDL #06-012 that reduce the harm to beneficiaries and the burden on state Medicaid agencies. 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. We also welcome 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 during the presumptive eligibility period regardless of whether they have documented their citizenship.

Unfortunately, the Rule does not do enough to insure that vulnerable U.S. citizens are not harmed by the implementation of Section 6036. We respectfully suggest that there are additional adjustments that ought to be made to the rules in order to protect access to critical medical services for vulnerable United States citizens.

I. PERSONS RECEIVING MEDICAID AS AN AUTOMATIC BENEFIT OF ENROLLMENT IN ANOTHER PROGRAM, INCLUDING ENROLLMENT IN TITLE IV-E OF THE SOCIAL SECURITY ACT, 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. Only those persons declaring that they are citizens or nationals of the United States for purposes of applying for Medicaid are impacted by the requirements of Section 6036 provision of the DRA.

> Section 6036 applies: "with respect to amounts expended for medical assistance for an individual who declares under 1137(d)(1)(A) to be a citizen or national of the United States **for purposes of establishing eligibility for benefits under this title**, unless the requirement of subsection (x) is met..." (*emphasis added, also note that the reference to "this title" is to Title XIX*)

- 1137(d)(1)A) reads as follows:
  - "The State shall require, as a condition of an individual's eligibility for benefits **under a program listed in subsection (b)** a declaration in writing, under penalty of perjury... stating whether the individual is a citizen or national of the United States ...."

Subsection (b) provides as follows:

- The programs which must participate in the income and eligibility verification system are:
  - (1) any State program funded under Part A of Title IV of this Act
  - (2) the medicaid program under Title XIX of this Act
  - The unemployment compensation program under section 3304 of the Internal Revenue Code of 1954
  - The food stamp program under the Food Stamp Act of 1977, and
  - Any State program under a plan approved under Title I, X, XIV, or XVI of this Act.

This language could not be more clear: Section 6036 applies to persons who receive Medicaid as a benefit, **AND** who declare under 1137(d)(1)(A) to be a citizen or national of the Unites States **for purposes of establishing eligibility for Medicaid.**

Those excluded from this definition are all persons applying for or enrolled in Medicaid who do not declare citizenship for purposes of establishing eligibility for Medicaid.

This group includes at least:

- Persons on SSI
- Foster/Adoptive children under Title IV-E
- Persons on TANF in states where receipt of Medicaid is linked to receipt of TANF (i.e. where a separate Medicaid application is not required) (this is true in Colorado; Medicaid is mandatory for persons on TANF, C.R.S. 26-4-201(1)(a))
- Persons on State only programs where Medicaid is an automatic benefit of that program.

Persons who qualify for Medicaid as a benefit of enrollment in separate benefits program, ought to be exempt from the requirements of Section 6036. At a minimum, 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 Section 6036 of the DRA.

II. 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.

§ 6036 of the DRA 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 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 treated worse than qualified alien applicants.

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.

III. 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 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. 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 distinction focuses on the wrong person. The Medicaid eligibility in question is that of the child, not the parent. All children born in the United States are U.S. Citizens, regardless of the immigration status of their parents. Differential treatment based on the citizenship or alienage of a child's parent raises equal protection issues.

It also defies logic to require children whose births are paid for by the Medicaid program to comply with the requirements of Section 6036. 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 thus is a U.S. citizen. States ought to be required, as they are already required both to observe minimum verification requirements and comply with an ex parte review process, to review and acknowledge their own records for proof of citizenship status of a newborn citizen baby.

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.

Finally, once it has been established that a newborn is a citizen of the United States, there is no reason why that child should have to establish his or her citizenship at age one. CMS has articulated very valid reasons for making the obligation to verify citizenship a one time requirement; there is virtually no chance that someone's status as a citizen will change over time. It is even more certain that a citizen newborn is not going to turn into a non citizen at age one. There is no reason why a child born under the Medicaid program should have to establish his or her citizenship at some later date.

IV. 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.

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, particularly for states such as Colorado, that appear to be taking the position that their obligation extends only to providing information about where applicants may go to secure the required documentation.

Finally, 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. CMS should also clarify that states should 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.

V. 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. 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.

It is highly unlikely that a family qualifying for Medicaid will have the resources to secure original copies of the required documents. First, the expense involved is significant for low income families, and particularly those with more than one child on Medicaid. In Colorado it cost $15.00 to get a birth certificate prior to implementation of the DRA; it now costs $17.00 for the same birth certificate. Clearly the burden of the DRA's unfunded mandate to states has been shifted to low income families, seniors and disabled Medicaid applicants. In addition to the out of pocket cost(s) of the document(s), most working parents are unable to take time off from work without jeopardizing their jobs, or losing wages because of the time lost from work. While we assume it was not the Administration's intent to create barriers to citizen access to Medicaid by attaching a cost to the application process, that is the result under the current Rule.

Another troubling aspect of this requirement arises from the fact that few applicants will be willing to send a valuable original document through the mail to their county Department of Social Services. In Colorado, documents are routinely lost when sent to at least certain county Social Service agencies, making it highly unlikely that anyone will be willing to submit original documents by mail. The requirement in the Rule thus imposes an unreasonable burden on applicants, a burden that will undo all of the work that has gone in to eliminating the requirement of a face to face application process in the Medicaid program and will be particularly hard on those with limited mobility.

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.

VI. 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.

VII. 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.

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. This approach would ensure that the citizens we represent can continue to receive the health care services they need.

VIII. 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 Arizona, for example, can later get Medicaid in Colorado 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

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

Very truly yours,

Elisabeth Arenales, Esq.
Healthcare Program Director
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(303) 573-5669 x 302

Planned Parenthood of Connecticut, Inc.
345 Whitney Avenue
New Haven, CT 06511
August 11, 2006

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

Re: 42 CFR Parts 435, 436, 440, 441, 457, and 483
Medicaid Program; Citizenship Documentation Requirements

Dear Administrator McClellan:

We are writing to comment on the interim final rule, published in the Federal Register on July 12, to implement section 6036 of the Deficit Reduction Act of 2005 (DRA). Section 6036 requires that all U.S. citizens applying for or receiving Medicaid benefits produce documentation proving citizenship. We are deeply concerned about the impact this provision will have on millions of Medicaid eligible citizens.

Planned Parenthood of Connecticut cared for over 62,000 patients last year, nearly ¼ of whom received services as clients of the federal Medicaid program. Most are between 18 and 25 years of age, and came to us seeking services to allow them to prevent unintended pregnancy, or to receive testing and treatment of sexually transmitted disease. These services are vital in order to help low income women plan both their families and the work experiences they will need in order to leave poverty behind.

We are disappointed that the Centers for Medicare and Medicaid Services (CMS) did not capitalize on the opportunity to lessen the negative impact of section 6036. Actually, in several instances, the interim final rule sets forth requirements that are more burdensome than what the statute calls for. Below, we highlight areas where CMS should modify the interim final rule to more effectively ensure that patients have timely access to the health care services they are eligible for and need.

We are especially concerned about the impact the interim final rule will have on individuals seeking family planning services. Nationwide, Medicaid is a significant source of funding for family planning and other preventive health care services we provide to our patients. This critical program is the largest source of public funding for family planning services, accounting for more than 60% of all publicly-funded care.

Individuals receiving benefits under section 1115 family planning demonstration programs should be exempt from the citizenship documentation requirements.

In 2005, the Connecticut General Assembly charged our State Department of Social Services with preparing an application for a family planning demonstration waiver. This application is still in the process of being written, and, when enacted, will be an important way to improve the health of young women by enabling them to access basic reproductive health care. Studies all show that annual "well woman" gynecological exams help to prevent unplanned pregnancy and to prepare young women so that they are in optimum health when they do decide to bear children.

Since 1993, twenty-four states have expanded access to family planning services through 1115 family planning demonstration programs. Under these programs, states have received CMS approval to extend Medicaid-covered family planning services to individuals who do not meet the requirements for standard Medicaid enrollment in order to prevent unintended pregnancies. Streamlining enrollment and extending coverage are fundamental to the success of these programs, which have assisted millions of low-income people who would otherwise have no source for family planning services. For many states, family planning demonstration programs are at the cornerstone of improvements in quality of health care. We hope that Connecticut will soon be among these states. The citizenship documentation requirements strike at the core of how family planning demonstration programs are designed and could render them meaningless.

The interim final rule completely threatens the viability and impact of these programs by requiring individuals who receive these services to produce citizenship documentation. The preamble of the interim final rule states that "individuals who are receiving benefits under a section 1115 demonstration project approved under title XI authority are also subject to the provision" (71 Fed. Reg. 39216 and 42 CFR 435.406(a)(1)(iii)).

This inclusion of family planning demonstration programs is entirely counterproductive. The point of these programs is to expand coverage and streamline access to critical services by waiving certain federal requirements under the Medicaid program. Services provided under the family planning demonstration programs are limited in scope, but their impact is tremendous. Each year, millions of women rely on these programs to prevent unintended pregnancies and to access other crucial health care services.

In addition to expanding access to such vital health care services, family planning demonstration programs have saved money in all of the states where they have been implemented. A 2003 study commissioned by CMS showed that in each of the states studied, the program actually saved money by averting unintended pregnancies. For instance, South Carolina realized a savings of $56 million over a three-year period while Oregon's program saved almost $20 million in a single year.

Requiring family planning demonstration program patients (who otherwise would not qualify for Medicaid coverage) to comply with a requirement for the broader Medicaid population completely undermines the programs by erecting unnecessary enrollment barriers. Furthermore, the citizenship documentation requirements would ultimately create a larger financial burden for the federal and state governments.

We strongly urge CMS to exempt this population from the documentation requirements in the final rule. Doing so will ensure that family planning waiver demonstration programs will continue to make important strides in enhancing access to time-sensitive services and reducing the rate of unintended pregnancies. Without such an exemption, states will be faced with the very real possibility that costs associated with requiring citizenship documentation will outweigh the savings the programs currently produce.

Individuals applying for Medicaid should receive benefits upon declaring citizenship.

Section 6036 of the DRA applies to all individuals (with the exception of Medicare beneficiaries and most SSI beneficiaries) who apply for Medicaid. For those individuals who are already receiving Medicaid benefits, the interim final rule stipulates that they will continue to be eligible for services while they are in the process of producing the required documentation during a "reasonable opportunity" period allotted to them. However, for those individuals who are newly applying to the program, the interim final rule firmly establishes that they will not be eligible for services until citizenship is proven (see 71 Fed. Reg. at 39216 and 42 CFR 435.407(j)). As a result, U.S. citizens applying for Medicaid who have met all eligibility criteria and are in the process of producing the documentation will experience significant delays in Medicaid coverage. This will have a substantial impact on clients in need of time-sensitive reproductive health care services.

As a result, in this year alone, approximately 10 million U.S. citizens applying for Medicaid will face the possibility of a gap in coverage while they are in the process of producing the required documentation. It should not be lost that the majority of these citizens will be low-income pregnant women, children, and other vulnerable Americans. Undoubtedly, this will result in delays in care, worsening health care problems and eventually placing a heavier burden on the health care system. This will have an especially negative impact on individuals in need of family planning services, cervical and breast cancer screening, and STI testing services. Some U.S. citizens who get discouraged or cannot produce the documents within the time allowed by the state will be denied coverage. Since an active outreach program has not been implemented, many citizens are unaware of the documentation requirements and are not prepared to comply.

Surprisingly, this requirement was not required by the DRA statute. There is nothing in the DRA that requires any delay in providing coverage for health care services. Unfortunately, CMS freely incorporated this provision into the interim final rule.

Moreover, delaying eligibility does not correspond with the statute. Under the DRA, documentation of citizenship is not a criterion of Medicaid eligibility. Instead, it is a criterion for states to receive federal financial participation (FFP). Once an applicant for Medicaid declares that he or she is a citizen and meets all eligibility requirements, he or she should be able to access Medicaid-covered services while attempting to produce the required documentation during the "reasonable opportunity" period.

We therefore urge CMS to revise the interim final rule at 42 CFR 435.407(j) to state that new Medicaid applicants who declare they are U.S. citizens or nationals and who meet the state's eligibility criteria must receive Medicaid-covered services while they are obtaining the necessary documentation during the "reasonable opportunity" period.

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

The interim final rule requires that individuals submit original or certified copies of documentation (see 42 CFR 435.407(h)(1)). This requirement creates an even larger burden for beneficiaries who will be faced with either the additional cost of purchasing a certified copy, making a face-to-face visit with state offices, or with entrusting important documentation, such as an original birth certificate or passport, to the postal system and state Medicaid agencies.

Attaining the required documents presents its own challenges. In Connecticut, each town manages the means of accessing birth certificates in a different manner. In most cases, there is a charge to the citizen for purchasing the document, as well as the additional barrier of requiring photo identification or other original documents. CMS's estimate that it will take 10 minutes for applicants and beneficiaries to comply with the requirements (see 71 Fed. Reg. 39220) appears unrealistic to anyone who has negotiated a local records-keeping bureaucracy. Delays in care will occur as a result of the document acquisition process —a harmful issue for those who will have to forgo reproductive health care services while they are attempting to attain the required documentation.

While the regulations state that individuals can submit documents by mail, it is unlikely that many will be comfortable mailing in originals or certified copies of birth certificates, final adoption decrees, or medical/life insurance records. It is completely impractical to mail in proof of identity, such as a driver's license or school identification card.

The requirement for the submission of original or certified copies also stands to curtail efforts states have made to streamline the Medicaid enrollment process. The requirement that only original and certified documents can be accepted is unreasonable and will undermine efforts to streamline and optimize enrollment of eligible individuals into the Medicaid program. In addition to the obstacle this creates for patients, this requirement makes it more likely that health care providers will experience delays in reimbursement as well as uncompensated care.

We strongly urge CMS to eliminate the requirement at 42 CFR 435.407(h)(1) that only originals or copies certified by the issuing agency can be accepted.

The final rule should allow states more flexibility to effectively implement the documentation requirements.

Connecticut should not be forced to implement a citizenship documentation process that is both burdensome and counterproductive. We recognize that the regulations are a significant improvement over the June 9th CMS guidance in that they explicitly allow

states to use vital health databases to document citizenship and other state and federal databases to document identity (see 71 Fed. Reg. 39216 and 42 CFR 435.407(e)(10)). At the same time, however, like other states, Connecticut is still bound by a proscriptive process that does not adequately allow it to respond to the unique needs of its population. In general, the hierarchy of document reliability that CMS chose creates a much larger burden than is necessary to implement section 6036. Specifically, there are several areas where CMS should amend the interim final rule.

While requiring states to help "special populations" in securing citizenship documentation is an important safeguard, it is unclear if this provision covers all individuals who may be in need of state assistance (see 42 CFR 435.407(g)). The provision applies to those who cannot acquire the documents because of "incapacity of mind or body." Conceivably, there are many groups of people who may be lost in this provision, such as victims of natural disasters and certain homeless individuals. CMS should erect a clear safety net for these populations as well. Furthermore, CMS should ensure that for these populations, eligibility for services cannot be denied as a result of a state's incapacity to locate the documentation.

In the interim final rule, CMS solicits comments on whether individuals would have difficulty proving citizenship and identity if only primary or secondary level documents were permitted (see 71 Fed. Reg. 39220). Given that many beneficiaries and applicants will face significant hurdles in documenting citizenship according to the provisions of the interim final rule, it would be enormously detrimental if the regulations were limited so severely in the final rule. Instead, CMS should approach the final rule in terms of broadening the scope of acceptable documentation. For instance, section 435.407(a) should be amended to allow Native American tribal identification documents to be used to prove both citizenship and identity.

We strongly urge CMS not to limit the accepted documentation to the primary and secondary level of documents. If the true goal of the provision is simply to require the proof of citizenship and identity of Medicaid-eligible U.S. citizens, then it is only natural that CMS would accept a variety of documents to reflect the varied circumstances of Medicaid-eligible citizens' lives.

Conclusion

The citizenship documentation requirements set forth by the Deficit Reduction Act will have a profound impact on the way Connecticut's Medicaid program operates. Because of this, we emphatically encourage CMS to use its full authority to lessen the severity of the section 6036.

Thank you for your attention to these comments.

Susan Lloyd Yolen, Vice President, Public Affairs & Communication
Planned Parenthood of Connecticut

August 9, 2006

Doctor Mark McClellan
PO Box 8017
Baltimore, MD 21244-8017

Dear Doctor McClellan,

Utah should not be forced to implement a citizenship documentation process that is both burdensome and counterproductive. We recognize that the regulations are a significant improvement over the June 9th CMS guidance in that they explicitly allow states to use vital health databases to document citizenship and other state and federal databases to document identity (see 71 Fed. Reg. 39216 and 42 CFR 435.407(e)(10)).

At the same time, however, Utah is still bound by a proscriptive process that does not adequately allow it to respond to the unique needs of their population. In general, the hierarchy of document reliability that CMS chose creates a much larger burden than is necessary to implement section 6036. Specifically, there are several areas where CMS should amend the interim final rule.

I strongly urge CMS not to limit the accepted documentation to the primary and secondary level of documents. If the true goal of the provision is simply to require the proof of citizenship and identity of Medicaid-eligible U.S. citizens, then it is only natural that CMS would accept a variety of documents to reflect the varied circumstances of Medicaid-eligible citizens' lives.

Thank you for your attention.

Sincerely,

Bethany Stackhouse
3223 Wheelock Student Center
University of Puget Sound
Tacoma, Washington 98416

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COMMUNITY
HEALTH NETWORK
OF WASHINGTON

August 9, 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

RE: Medicaid Citizenship Documentation Interim Final Rule, 71 Fed.Reg. 39214 (7/12/06)

Dear Ms. Musotto:

The Community Health Network of Washington is a community health center-based delivery network and the parent company of Community Health Plan, one of the largest safety net managed care plans in the country. Our system serves nearly 600,000 low-income patients across nearly every county in Washington State. About 40% or 230,000 of the patients in our network are Medicaid enrollees, representing more than ¼ of the state's Medicaid caseload. We are thereby extremely concerned that U.S. citizens applying for or receiving Medicaid coverage will face delay, denial, or loss of Medicaid coverage.

We are writing to comment on the interim final rule 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.

Our comments below highlight these seven key areas that we believe should be modified in the final rule.

Information collection requirements
We are concerned that the requirement that only originals and certified copies be accepted as satisfactory documentary evidence of citizenship adds unnecessarily 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. 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. This approach means scarce resources will be spent on bureaucratic processes rather than on needed health care services.

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. It also requires states to dedicate precious additional resources to handle the added bureaucratic workload created by this requirement.

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, or proof of identity such as driver's licenses or school identification cards.

We urge CMS to 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.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.

The net effect of denying coverage to applicants lacking documentation 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.

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.

We urge CMS to revise 42 CFR 435.407(j) to state that applicants declaring they are U.S. citizens or nationals and meeting the state's Medicaid eligibility criteria are eligible for Medicaid. Furthermore, we urge CMS to require states to provide applicants with Medicaid coverage during a "reasonable opportunity" period for obtaining 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 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. (It has been reported that CMS takes the view that foster care children should be treated as current beneficiaries rather than applicants for this purpose, but there is no language to this effect in either the rule itself or the preamble.)

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 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.

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 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.

This result is both foreseeable and unnecessary. 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. 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 the patients we serve who are U.S. citizens can continue to receive the health care services they need.

Those receiving Medicaid through family planning waivers should be exempt.
The population receiving Medicaid through family planning waivers will experience unnecessary, inordinate delays in service provision if they are required to wait to receive services until the proper documentation can be obtained. Services delays to this population would have negative consequences and therefore they should be exempted from the requirement. Washington State's family planning program has proven very effective in limiting unwanted pregnancies and we fear that these rules will erase the progress made over many years.

American Indians 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 American Indian tribal documents as proof of identity, the regulations do not permit tribal enrollment cards to be used as evidence of citizenship. (The regulations only allow identification cards issued by DHS 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). 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 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.

By not recognizing tribal enrollment cards as proof of citizenship and identity, CMS is creating a barrier to American Indian participation in the Medicaid program. This action also will lead to an increase in uninsured American Indians, further straining community health centers and Indian health clinics that comprise a key part of the health care safety net. Therefore, the federal regulation should be revised to specify that tribal enrollment cards issued by a federally-recognized tribe should be acceptable primary evidence of citizenship and identity. County, public and private providers serving these patients may be at risk for losing Medicaid reimbursements.

In conclusion, the interim final rules for the citizenship verification provision in the DRA create unnecessary bureaucratic obstacles to applicants and beneficiaries. These rules are likely to have the following negative impacts:

- An increase in the number of uninsured patients;
- Avoidance of appropriate care by vulnerable, low-income patients;
- An increase in cost to insured people and taxpayers due to more cost-shifting; and
- Added strain on the already overburdened health care safety net.

We urge you to modify the interim final regulation to ensure that eligible citizens – as was the intent of this provision of the DRA – continue to have access to Medicaid coverage and that scarce Medicaid dollars can be spent on health care services rather than administration.

Sincerely,

Rebecca Kavoussi
Director of Public Policy

STATE ADVISORY COUNCIL ON MENTAL HEALTH

and Subcommittee on Children's Mental Health

Council/Subcommittee Web Site:
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August 7, 2006

Mark McClellan, M.D. Ph.D., Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Interim Final Rule on Medicaid Program; Citizenship Documentation Requirements [CMS-2257-IFC]

Dear Dr. McClellan:

The Minnesota State Advisory Council on Mental Health is charged with advocating for all persons with mental health needs in our state and so we submit these comments to you on the Citizen Documentation Requirements in the Interim Final Rule for the Medicaid program.

Often persons with mental illnesses rely on Medicaid for services and prescription coverage. Medicaid has been critical to improving access to mental health treatment, especially community-based care. The new documentation requirement for Medicaid will undoubtedly take an especially heavy toll on individuals with mental illnesses.

The rule, as published, provides little real accommodation to the kind of functional and cognitive impairments that some individuals with mental illness experience. For example, some mental health disorders disrupt organizational skills. Yet these are among the very skills required to maintain and keep track of the kinds of records called for by this new requirement. Those with very serious mental health disorders are often transient and change providers frequently. Such circumstances markedly complicate the challenge of complying with the requirements CMS has established.

In particular, we urge CMS to

- Specify that states must make every effort to simplify this process for individuals with mental or physical conditions that make it difficult for them to comply with the new documentation requirement--this would include those who are homeless, victims of disasters and foster children.
- Press states to use electronic means to verify citizenship and identity whenever possible.

- Specify that affidavits from providers of long term care or rehabilitation services may suffice to demonstrate the identity of an applicant or recipient who has a disability and for whom providing other more standard forms of identity presents a real hardship;

- For individuals who simply cannot provide any of the designated documents or affidavits, allow states to base a determination on all the evidence that is available and to allow or continue enrollment as long as there are reasonable grounds to conclude the applicant or recipient is a citizen;

- Explain that states may accept copies or notarized copies of documents when there is no reason to believe these copies are counterfeit, altered or inconsistent with information previously supplied by the applicant or recipient;

- Specify that applicants cannot be denied eligibility simply because they failed to meet a state's reasonable opportunity time standards and once this reasonable opportunity period has ended, make clear that states must help individuals who are still having difficulty producing the required documents;

- Clarify that once applicants or recipients have met the documentation requirement in one state, they will not be required to demonstrate citizenship again for Medicaid enrollment if they move to another state.

Thank you for your assistance in ensuring that those who rely on Medicaid services in order to maintain their mental health will not lose access to these services as a result of one of the effects of their mental illness.

Sincerely,

Bruce Weinstock
Director
Minnesota State Advisory Council on Mental Health

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20852

712

AUG 11 2006

TO: Administrator
Centers for Medicare & Medicaid Services

FROM: Director
Indian Health Service

SUBJECT: Agency Comments on HHS Interim Final Rule: Medicaid Program; Citizenship Requirements.

The Indian Health Service (IHS) is respectfully submitting comments on the HHS Interim Final Rule: Medicaid Program; Citizenship Documentation Requirements, 71 FR 39214 (July 12, 2006); File Code CMS-2257-IFC. This interim final rule (IFR) amends Medicaid regulations to implement the Deficit Reduction Act (DRA) that requires States to obtain satisfactory documentary evidence of the citizenship and identity of a Medicaid applicant or recipient.

The IFR, as currently written, will have a direct, adverse impact on the Agency's American Indian/Alaskan Native (AI/AN) Medicaid beneficiary population. The IHS believes that a Tribal enrollment card or Certificate Degree of Indian Blood (CDIB) card should meet the standard for proof of citizenship. While the IFR recognizes "Indian documents" under §435.407(e)(6) a Native American Tribal Document, and under §435.407(e)(9) a Certificate Degree of Indian Blood or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual; under the current IFR, both of these documents only meet the requirements regarding evidence of identity and not evidence of citizenship. Thus, IHS Medicaid-eligible patients must still provide proof of citizenship.

In order to provide proof of citizenship under §435.407, a person must provide proof of documentation within four levels. If an individual is unable to provide documentation under the primary level, then he/she must provide both proof of citizenship and proof of identity. Examples of acceptable documents include a U.S. Passport (Level 1 – Primary evidence) or birth certificate (Level 2 – Secondary evidence). Due to the unique circumstances of Indian Country and Indian people, the IHS is concerned that most AI/ANs have never obtained a U.S. passport, and many others may not even have a birth certificate due to the high rate of home deliveries. The IHS requests that a Tribal enrollment card or CDIB card be added as acceptable primary evidence (Level 1).

It is well-noted that AI/ANs already face numerous existing barriers to accessible healthcare. The Medicaid program is an integral component of the Indian healthcare system. When an AI/AN Medicaid beneficiary/applicant is unable to provide proof of citizenship documentation under these regulations, they will be disenrolled and/or deemed ineligible from the Medicaid

Program, further perpetuating the health disparities of AI/AN people by reducing access to quality healthcare. This result would also have a major impact on the IHS's revenue and continue to overburden an already under-funded program by prohibiting the Agency's ability to bill Medicaid for those disenrolled/ineligible AI/ANs.

Finally, it is the IHS's understanding that under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), members of Indian Tribes, regardless of citizenship status, are eligible for Federal public benefits, including Medicaid. Pursuant to 62 FR 61344 (November 17, 1997), non-citizen Native Americans who are born outside of the United States who are either (1) were born in Canada and are at least 50 percent 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. Under PRWORA, the documentation requirement is a Tribal 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. The documentation requirements under the DRA should be consistent with current Federal law and regulations under PRWORA.

Thank you for the opportunity to provide comments on this IFR.

Charles W. Grim, DDS

Charles W. Grim, D.D.S., M.H.S.A.
Assistant Surgeon General

Attachment

effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government). *6. Executive Order 13175: Consultation and Coordination with Indian Tribal Governments*—EO 13175 does not apply to this rule because it will not have tribal implications (i.e., substantial direct effects on one or more Indian tribes, on the relationship between the Federal Government and Indian tribes, or on the distribution of power and responsibilities between the Federal Government and Indian tribes). *7. Executive Order 13045: Protection of Children from Environmental Health & Safety Risks*—This rule is not subject to EO 13045 because it is not economically significant and it is not based on health or safety risks. *8. Executive Order 13211: Actions that Significantly Affect Energy Supply, Distribution, or Use*—This rule is not subject to EO 13211 because it is not a significant regulatory action as defined in EO 12866. *9. National Technology Transfer and Advancement Act*—Section 12(d) of the National Technology Transfer and Advancement Act of 1995 ("NTTAA"), Public Law 104–113, 12(d) (15 U.S.C. 272 note) directs EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. Voluntary consensus standards are technical standards (e.g., materials specifications, test methods, sampling procedures, and business practices) that are developed or adopted by voluntary consensus standards bodies. The NTTAA directs EPA to provide Congress, through OMB, explanations when the Agency decides not to use available and applicable voluntary consensus standards.

This action does not involve technical standards. Therefore, EPA is not considering the use of any voluntary consensus standards.

List of Subjects in 40 CFR Part 281

Environmental protection, Administrative practice and procedure, Hazardous materials, State program approval, Underground storage tanks.

Authority: This notice is issued under the authority of Sections 2002(a), 7004(b), and 9004 of the Solid Waste Disposal Act as amended 42 U.S.C. 6912(a), 6974(b), and 6991(c).

Dated: June 5, 2006.

Bharat Mathur,

Acting Regional Administrator, Region 5.

[FR Doc. E6–10866 Filed 7–11–06; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 435, 436, 440, 441, 457, and 483

[CMS–2257–IFC]

RIN 0938–AO51

Medicaid Program; Citizenship Documentation Requirements

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Interim Final rule with comment period.

SUMMARY: This interim final rule with comment period amends Medicaid regulations to implement the provision of the Deficit Reduction Act that requires States to obtain satisfactory documentary evidence of an applicant's or recipient's citizenship and identity in order to receive Federal financial participation. This regulation provides States with guidance on the types of documentary evidence that may be accepted, including alternative forms of documentary evidence in addition to those described in the statute and the conditions under which this documentary evidence can be accepted to establish the applicant's declaration of citizenship. It also gives States guidance on the processes that may be used to help minimize the administrative burden on both States and applicants and recipients.

DATES: *Effective Date:* July 6, 2006.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on August 11, 2006.

ADDRESSES: In commenting, please refer to file code CMS–2257–IFC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (no duplicates, please):

1. *Electronically.* You may submit electronic comments on specific issues in this regulation to *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Submit electronic comments on CMS regulations with an open comment period." (Attachments should be in Microsoft Word, WordPerfect, or Excel; however, we prefer Microsoft Word.)

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2257–IFC, P.O. Box 8017, Baltimore, MD 21244–8017.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–2257–IFC, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

(Because access to the interior of the HHH Building is not readily available to persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by mailing your comments to the addresses provided at the end of the "Collection of Information Requirements" section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Robert Tomlinson, (410) 786–4463.

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–2257–IFC and the specific "issue identifier" that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.cms.hhs.gov/eRulemaking.* Click on the link "Electronic Comments on CMS Regulations" on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

I. Background

Since enactment of the Immigration Reform and Control Act of 1986 (Pub. L. 99–163, enacted on November 6, 1986), Medicaid applicants and recipients have been required by section 1137(d) of the Social Security Act (the Act) to declare under penalty of perjury whether the applicant or recipient is a citizen or national of the United States, and if not a citizen or national, that the individual is an alien in a satisfactory immigration status. Aliens who declare they are in a satisfactory immigration status have been required by section 1137(d) of the Act to present documentation of satisfactory immigration status since the declarations were first implemented. Individuals who declared they were citizens did not have to do anything else to support that claim, although some States did require documentary evidence of this claim. The new provision under section 6036 of the Deficit Reduction Act of 2005 (DRA) (Pub. L. 109–171, enacted on February 8, 2006) effectively requires that the State obtain satisfactory documentation of a declaration of citizenship. Self-attestation of citizenship and identity is no longer an acceptable practice. The provisions of section 6036 of the DRA do not affect individuals who have declared they are aliens in a satisfactory immigration status. As with other Medicaid program requirements, States must implement an effective process for assuring compliance with documentation of citizenship and identity in order to obtain Federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring.

Section 6036 of the DRA creates a new section 1903(x) of the Act that prohibits Federal financial participation (FFP) in State expenditures for medical assistance with respect to an individual who has declared under section 1137(d)(1)(A) of the Act to be a citizen or national of the United States unless the State obtains satisfactory documentary evidence of citizenship or a statutory exemption applies. For new Medicaid applicants or for currently enrolled individuals, the State must obtain evidence of citizenship and identity at the time of application or at the time of the first redetermination occurring on or after July 1, 2006. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in the case file or database, subsequent changes in eligibility should not require repeating the documentation unless later evidence raises a question of a person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

Basic Features of New Provision

To receive FFP, States must secure documentary evidence of U.S. citizenship and identity with respect to individuals who have declared under section 1137(d) of the Act that they are citizens or nationals of the United States unless an exemption applies. These individuals must present documentary evidence to establish both citizenship and identity. The law provides specific examples of acceptable documents and gives us authority to add additional documents. We explain the types of documents that may be used including additional documents that may be accepted. We establish a hierarchy of reliability of citizenship documents and specify when a document of lesser reliability may be accepted by the State. The State makes the decision whether documents of a given level of reliability are available.

Implementation Conditions/ Considerations

The State must obtain satisfactory documentary evidence of citizenship and identity for all Medicaid applicants who have declared that they are citizens or nationals of the United States. This requirement applies to all recipients who declared at the time of application to be citizens or nationals of the United States unless an exemption applies. Section 1903(x)(2) of the Act provides an exemption, but it does so in a manner that is clearly a drafting error. This section exempts an "alien" eligible for Medicaid and entitled to or enrolled in Medicare or eligible for Medicaid by virtue of receiving Supplemental Security Income (SSI) from the requirement to present satisfactory documentary evidence of citizenship. However, because aliens are not citizens and cannot provide documentary evidence of citizenship, this exemption, if limited to aliens, does not appear to have any impact. The context of this exemption in the statutory framework suggests that the Congress may have intended to create an exemption for citizens and nationals but accidentally used the term "alien." The DRA did not modify section 1137(d)(2) or (3) of the Act, which contains the documentation and verification requirements for aliens, and section 1903(x)(1), which was added by the DRA and is the section to which the exemption applies, by its terms references only citizens and nationals, not aliens.

We believe that in order to give meaning to the exemption, it is appropriate to treat the reference to "alien" as a "scrivener's error." Courts have employed the doctrine of correcting a "scrivener's error" in order to correct obvious clerical or typographical errors. For example, *U.S. Nat'l Bank of Or.* v. *Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 462 (1993). Courts similarly may reform the Congress's chosen words when the plain language would lead to absurd results. See *Yates* v. *Hendon*, 541 U.S. 1, 17–18 (2004); *United States* v. *Brown*, 333 U.S. 18, 27 (1948). There are several clear scrivener's errors included in section 6036 of the DRA in addition to this one, including the Congress's decision to cross-reference the non-existent "subsection (i)(23)," rather than the relevant subsection (i)(22).

While the Congress chose to use words that have a logical English meaning, those words lead to absurd and counter-intuitive results. An exemption applying only to "aliens" who declare themselves citizens would amount to an absurd result for aliens (who, by definition, cannot provide documentation of citizenship) and no exemption at all for those whom the Congress clearly intended to benefit with the exemption. Under the absurd results doctrine, it appears reasonable for CMS to interpret the statute so that the exemption under subsection 1903(x)(2) of the Act applies to "individuals" rather than "aliens."

To adopt the literal reading of the statute could result in Medicare and SSI eligibles, a population which are by definition either aged, blind, or

disabled, and thereby most likely to have difficulty obtaining documentation of citizenship, being denied the availability of an exemption which we believe the Congress intended to afford them. Accordingly, States will not be subject to denial of FFP in their Medicaid expenditures for SSI recipients who receive Medicaid by virtue of receipt of SSI and Medicare eligibles based upon failure to document citizenship.

Not all States provide Medicaid to individuals who are SSI recipients. In those States, the exemption will not provide relief to SSI recipients. However, the Social Security Administration (SSA) maintains a database, known as the State Data Exchange (SDX) which contains the needed information to identify whether an individual has already been found to be a citizen by the SSA and the States have the option to cross match with this database to meet these requirements without using the hierarchical process for obtaining documents discussed in the regulation.

The statute also gives us authority to exempt "aliens" (which we construe as "individuals who declare themselves to be citizens or nationals") from the documentation requirements if satisfactory documentary evidence of citizenship or nationality has been previously presented. We are not currently exercising this authority. If we become aware of an appropriate instance to exercise this authority in the future or to add additional forms of documentation which will be acceptable for establishing identity or citizenship, we will do so by regulation.

Title IV–E children receiving Medicaid, while not required to declare citizenship for IV–E, must have in their Medicaid file a declaration of citizenship or satisfactory immigration status and documentary evidence of the citizenship or satisfactory immigration status claimed on the declaration.

Individuals who are receiving benefits under a section 1115 demonstration project approved under title XI authority are also subject to this provision. This includes individuals who are treated as eligible for matching purposes by virtue of the authority granted under section 1115(a)(2) of the Act (expansion populations) under section 1115 demonstrations and family planning demonstrations.

Under section 1902(e)(4) of the Act and 42 CFR 435.117, a Medicaid agency must provide categorically needy Medicaid eligibility to a child born to a woman who is eligible as categorically needy and is receiving Medicaid on the date of the child's birth. The child is deemed to have applied and been found eligible for Medicaid on the date of birth and remains eligible as categorically needy for one year so long as the woman remains eligible as categorically needy and the child is member of the woman's household. Citizenship and identity documentation for the child must be obtained at the next redetermination of eligibility. Citizen children born to non-qualified aliens do not benefit from the provisions of section 1902(e)(4) of the Act because although the mother may have been eligible for and receiving Medicaid on the date of the child's birth, the mother would not continue to be eligible after the child's birth. The mother is eligible for Medicaid but only for treatment of an emergency medical condition. A child born in the United States to an illegal alien mother, or 5-year bar qualified alien mother is not a deemed newborn under 1902(e)(4) because the mother although eligible on the date of birth of the child, would not remain eligible. The child, however, could be eligible as a poverty level child, or 1931 child. In these cases an application must be filed for the child and the requirements of this regulation would apply at the time of application.

Individuals who receive Medicaid because of a determination by a qualified provider, or entity, under sections 1920, 1920A, or 1920B of the Act (presumptive eligibility) are not subject to the documentation requirements until they file an application 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, including the requirements of section 1903(x) of the Act. However, when these individuals file an application for Medicaid and declare on the application that they are citizens or nationals, these regulations would apply for periods in which they receive services as eligible for Medicaid.

At the time of application or redetermination, the State must give an applicant or recipient, who has signed a declaration required by section 1137(d) of the Act and claims to be a citizen, a reasonable opportunity to present documents establishing U.S. citizenship or nationality and identity. Individuals who are Medicaid recipients, will remain eligible until determined ineligible as required by Federal regulations at § 435.930. A determination terminating eligibility may be made after the recipient has been given a reasonable opportunity to present evidence of citizenship or the State determines the individual has not made a good faith effort to present satisfactory documentary evidence of citizenship. By contrast, applicants for Medicaid (who are not currently receiving Medicaid), should not be made eligible until they have presented the required evidence. This is no different than current policy regarding information which an initial applicant must submit in order for the State to make an eligibility determination.

The "reasonable opportunity period" should be consistent with the State's administrative requirements such that the State does not exceed the time limits established in Federal regulations for timely determination of eligibility in § 435.911. The regulations permit exceptions from the time limits when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In these cases, the State must assist the individual in securing evidence of citizenship.

States, at their option, may use matches with the SDX (if the State does not provide automatic Medicaid eligibility to SSI recipients) or vital statistics agencies in place of a birth certificate to assist applicants or recipients to meet the requirements of the law. For example, States already receive the SDX. Therefore, a match of Medicaid applicants or recipients to the SDX that shows the individual has proved citizenship would satisfy the documentation requirement of this provision with respect to SSI recipients. An SSI recipient's citizenship status can be found in the Alien Indicator Code at position 578 on the SDX. States may also, at their option, use matches with State vital statistics agencies in place of a birth certificate to establish citizenship.

We are soliciting comments and suggestions for the use of other electronic data matches with other governmental systems of records that contain reliable information about the citizenship or identity of individuals.

We will also permit States to accept documentary evidence without requiring the applicant or recipient to appear in person. However, States may accept original documents in person, by mail, or by a guardian or authorized representative.

Although States may continue to use application procedures that do not include an interview with an applicant, the State must assure that the information it receives about the identity and citizenship of the applicant or recipient is accurate.

All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.

The enactment of section 6036 of the DRA does not change any Centers for Medicare & Medicaid Services (CMS) policies regarding the taking and processing of applications for Medicaid except the new requirement for presentation of documentary evidence of citizenship. Before the enactment of section 6036 of the DRA, States, although not required by law or regulation to document citizenship, were required to assure that eligibility determinations were accurate. Therefore, most States would request documentation of citizenship only if the applicant's citizenship was believed to be questionable. Likewise, the regulations at § 435.902, § 435.910(e), § 435.912, § 435.919 and § 435.920 continue to apply when securing from applicants and recipients documentary evidence of citizenship and identity. Thus, States are not obligated to make or keep eligible any individual who fails to cooperate with the requirement to present documentary evidence of citizenship and identity. Failure to provide this information is no different than the failure to provide any other information which is material to the eligibility determination.

An applicant or recipient who fails to cooperate with the State in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant or recipient, or that individual's representative, after being notified, to present the required evidence or explain why it is not possible to present such evidence of citizenship or identity. Notice and appeal rights must be given to the applicant or recipient if the State denies or terminates an individual for failure to cooperate with the requirement to provide documentary evidence of citizenship or identity in accordance with the regulations at 42 CFR 431.210 or 431.211 as appropriate.

Federal Financial Participation (FFP) for Administrative Expenditures

We will provide FFP for State expenditures to carry out the provisions of section 1903(x) of the Act at the match rate for program administration.

Compliance

FFP will not be available for State expenditures for medical assistance if a State does not require applicants and recipients to provide satisfactory documentary evidence of citizenship, or does not secure this documentary evidence which includes the responsibility to accept only authentic documents on or after July 1, 2006. We will review implementation of section 6036 of the DRA to determine whether claims for FFP for services provided to citizens should be deferred or disallowed. Additionally, we will monitor the extent to which the State is using primary evidence to establish both citizenship and identity and will require corrective action to ensure the most reliable evidence is routinely being obtained.

We require that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number (SSN) that was provided as part of the SSN verification specified in § 435.910. In addition, the Federal government encourages States to use automated capabilities through which a State would be able to verify citizenship and identity of Medicaid applicants. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and documents to verify identity, and we will make available to States necessary information in this regard in a future State Medicaid Director's letter. States must ensure that all case records within this category will be so identified and made available to conduct these automated matches. We may also require States to match files for individuals who used first or second level documents to verify citizenship as well. We may provide further guidance to States with respect to actions required in a case of a negative match.

In addition, in the conduct of determining or re-determining eligibility for Medicaid, State Medicaid agencies may uncover instances of suspected fraud. In such instances, State agencies would refer cases of suspected fraud to an appropriate enforcement agency pursuant to the requirements of § 455.13(c) and § 455.15(b). We are soliciting comments and suggestions on whether, as a part of this policy, CMS should develop a more formal process of sharing the information obtained by States from the checks performed through the existing and any future automated capabilities that may indicate potential fraud. HHS recognizes that in cases where the appropriate enforcement agency is a Federal entity, the Privacy Act of 1974 applies to citizens and permanent resident aliens, and privacy protections afforded by law and in accordance with Federal policy will be addressed.

II. Provisions of the Interim Final Rule With Comment Period

[If you choose to comment on issues in this section, please include the caption "Provisions of the Interim Final Rule with Comment Period" at the beginning of your comments.]

We are amending 42 CFR chapter IV as follows:

We are amending § 435.406 and § 436.406 to require that States obtain a Declaration signed under penalty of perjury from every applicant for Medicaid that the applicant is a citizen or national of the United States or an alien in a satisfactory immigration status, and require the individual to provide documentary evidence to verify the declaration. The types and forms of acceptable documentation of citizenship are specified in § 435.407 and § 436.407. For purposes of this regulation the term "citizenship" includes status as a "national of the United States." The requirement to sign a Declaration of citizenship or satisfactory immigration status was added by the Immigration Reform and Control Act of 1986 and was effective upon enactment.

At the time section 1137(d) of the Act was enacted, aliens declaring themselves to be in a satisfactory immigration status were the only applicants required to present to the State documentary evidence of satisfactory status. Beginning in 1987, States were also required to verify the documents submitted by aliens claiming satisfactory immigration status with the Immigration and Naturalization Service (INS) (now the Department of Homeland Security) using the Systematic Alien Verification for Entitlements (SAVE).

The regulation requires the State to also obtain satisfactory documentary evidence establishing identity and citizenship from all Medicaid applicants who, under the DRA amendments, are required to file the Declaration. In addition, for current Medicaid recipients, States are required to obtain satisfactory documentary evidence establishing citizenship and identity at the time of the first redetermination of eligibility that occurs on or after July 1, 2006.

We are also amending § 435.406 and § 436.406 to define "Satisfactory immigration status as a Qualified Alien" as described in 8 U.S.C. 1641(b). We are also amending § 435.406 and § 436.406 to remove paragraphs (b) and (d), as well as subparagraphs (3) and (4) of paragraph (a). These provisions have ceased to have any force or effect because the eligibility status provided to individuals who received Lawful Temporary Residence under the

Immigration and Reform and Control Act (IRCA) of 1986 has expired or been superseded by the terms of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (Pub. L. 104–193, enacted on August 22, 1996). Lawful Temporary Resident Status was granted for a limited time to individuals who applied for the amnesty authorized by IRCA. Most individuals receiving this status would have achieved lawful permanent resident status by 1996 when PRWORA was enacted. PRWORA declared that "notwithstanding any other law" individuals who did not have status as a qualified alien as defined in 42 U.S.C. 1641 are not eligible for any Federal public benefit. That term includes Medicaid.

We are adding a new § 435.407 and a new § 436.407 describing the documents and processes States may use to document an applicant's or recipient's declaration that the individual is a citizen of the United States. The documents include all the documents listed in section 6036 of the DRA plus additional documents. We also note that the State Medicaid agency determinations of citizenship are not binding on other Federal or State agencies for any other purposes. We have employed a hierarchy of reliability when securing documentary evidence of citizenship and identity. To establish U.S. citizenship the document must show: A U.S. place of birth, or that the person is a U.S. citizen. Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens because they are not subject to the jurisdiction of the United States. To establish identity a document must show evidence that provides identifying information that relates to the person named on the document.

We have divided evidence of citizenship into groups based on the respective reliability of the evidence. The first group of documents is described in section 6036 of the DRA and is specified in § 435.407(a) and § 436.407(a) as primary evidence of citizenship and identity. If an individual presents documents from this section, no other information would be required. Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. The statute provides that these documents can be used to establish both the citizenship and identity of an individual. In general, a State should obtain primary evidence of citizenship and identity before using secondary evidence. We also permit States to use the State Data Exchange (SDX) database provided by SSA to all States that reflects actions taken by SSA to determine eligibility of applicants for the Supplemental Security Income (SSI) program. While in States which provide Medicaid eligibility to individuals by virtue of receipt of SSI, these data will not be relevant, the other States may use these data since SSA establishes the citizenship, or immigration status and identity of every applicant as part of its routine administrative processes.

Secondary Evidence of Citizenship

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. In addition, a second document establishing identity must also be presented. See § 435.407(e) and § 436.407(e). Available evidence is evidence that exists and can be obtained within a State's reasonable opportunity period. The State must accept any of the documents listed in paragraph (b) if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen. Applicants or recipients born outside the U.S. who were not citizens at birth must submit a document listed under primary evidence of U.S. citizenship. However, children born outside the United States and adopted by U.S. citizens may establish citizenship using the process established by the Child Citizenship Act of 2000 (Pub. L. 106–395, enacted on October 30, 2000). The second group of documents consists of a mix of documents listed in section 6036 of the DRA and additional documents that only establish citizenship. This group includes a U.S. birth certificate. The birth record document may be recorded by the State, Commonwealth, Territory or local jurisdiction. It must have been recorded before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.

If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories.

The following will establish U.S. citizenship for collectively naturalized individuals:

Puerto Rico:

- Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or
- Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

U.S. Virgin Islands:

- Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or
- The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or
- Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or
- Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration before January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or
- Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time).

If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

However, individuals born to foreign diplomats residing in one of the States, the District of Columbia, Puerto Rico, Guam, or the Virgin Islands are not citizens of the United States.

Third Level of Evidence of Citizenship

Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used only when primary evidence cannot be obtained

within the State's reasonable opportunity period (see reasonable opportunity discussion below), secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. In addition, a second document establishing identity must be presented as described in paragraph (e), "Evidence of identity."

A State must accept any of the documents listed in paragraph (c) as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (for example, lost U.S. citizenship).

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree.

Fourth Level of Evidence of Citizenship

Fourth level evidence of U.S. citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e), "Evidence of identity." Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

A State must accept any of the documents listed in paragraph (d) as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (for example, lost U.S. citizenship). Fourth level evidence consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. The written affidavit described in this section may be used only when the State is unable to secure evidence of citizenship listed in any other groups.

Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply: There must be at least two affidavits by individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit). At least one of the individuals making the affidavit cannot be related to the applicant or recipient and cannot be the applicant or recipient. In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity. If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained. The affidavits must be signed under penalty of perjury.

We are adding a paragraph (e) that consists of documents establishing identity. These are a mix of documents included in section 6036 of the DRA as evidence of identity, such as drivers' licenses and State identity cards. It also includes Native American Tribal enrollment documents, such as the Certificate of Degree of Indian Blood.

These documents, when coupled with satisfactory documentary evidence of citizenship from lists (b) through (d), will meet the statutory requirements of section 6036 of the DRA.

We are adding a paragraph (f) that describes special rules for individuals under the age of 16. Because children often do not have identification documents with photographs and a child's appearance changes significantly until adulthood, we permit parents or guardians to sign an affidavit as to the identity of the child. This affidavit does not establish citizenship and should not be confused with the affidavit permitted in rare situations to establish citizenship.

We are also adding a new paragraph (g) that describes rules for States to address special populations who need additional assistance. For example, if an individual is homeless, an amnesia victim, mentally impaired, or physically incapacitated and lacks someone who can act for the individual, and cannot provide evidence of U.S. citizenship or identity, the State must assist the applicant or recipient to document U.S. citizenship and identity.

We are adding a paragraph (h) that describes documentary evidence. We specify that the State can only review originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted for submission. The State, however, must keep copies of documentation for its files. States must maintain copies in the case record or its data base. The copies maintained in the case file may be electronic records of matches, or other electronic methods of storing information.

Moreover, we specify that individuals may submit documents by mail or other means without appearing in person to submit the documents. If, however, the documents submitted appear inconsistent with pre-existing information, are counterfeit or altered, States should investigate the matter for potential fraud and abuse. States are encouraged to utilize cross matches and other fraud prevention techniques to ensure identity is confirmed.

We specify in paragraph (i) that once a person's citizenship is documented and recorded in the individual's permanent case file, subsequent changes in eligibility should not ordinarily require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship, or there is a gap of more than 3 years between the individual's last period of eligibility and a subsequent application for Medicaid. We use a record retention period of 3 years throughout the Medicaid program as provided in 45 CFR 74.53. To require a longer retention period would be an unreasonable imposition on State resources.

Lastly, in paragraph (j), we describe the reasonable opportunity to submit satisfactory documentary evidence of citizenship and identity. We specify that a reasonable opportunity must meet the competing goals of providing sufficient time for applicants or recipients to secure documentary evidence and the requirements placed on States to determine, or redetermine eligibility promptly. These goals derive from sections 1902(a)(19) and 1902(a)(8) of the Act respectively. For example, States may use the reasonable period they provide to all applicants and recipients claiming satisfactory immigration on the Declaration required by section 1137(d) of the Act.

We also solicit comments and suggestions for additional documents that are a reliable form of evidence of citizenship or a reliable form of identity that have not been included in this regulation. Suggestions should include an explanation as to the reliability of such additional documents, including any limits on the document's reliability and methods for assuring reliability. We are also soliciting comments as to whether the number of documents accepted for proof of citizenship and

identity should be limited. In particular, in light of the exception provided for citizens and nationals receiving SSI where receipt of SSI results in Medicaid eligibility, and for individuals entitled to or enrolled in Medicare, we are soliciting comments as to whether individuals would have difficulty proving citizenship and identity if only primary or secondary level documents were permitted.

We are removing § 435.408 and § 436.408 because the immigration status described as permanently residing in the United States under color of law no longer has any effectiveness because of the enactment in 1996 of the Personal Responsibility and Work Opportunity Reconciliation Act which provides that "notwithstanding any other law" an alien who is not a qualified alien as defined in 42 U.S.C. 1641 is not eligible for any Federal public benefit. The Conference Report accompanying Public Law 104–193 declares on page 383, "Persons residing under color of law shall be considered to be aliens unlawfully present in the United States * * *"

We are redesignating § 435.1008 through § 435.1011 as § 435.1009 through § 435.1012, respectively. We are redesignating § 436.1004 and § 436.1005 as § 436.1005 and § 436.1006, respectively. We are correcting cross references in title 42 to the redesignated sections. We are adding a reference in § 435.1002(a) to new § 435.1008 conditioning FFP on State compliance with the requirements of section 1903(x) of the Act and these regulations. We are adding a new § 435.1008 and a new § 436.1004 to provide that FFP will be available if the State complies with the requirements of section 1903(x) of the Act and § 435.407 and § 436.407 regarding obtaining satisfactory documentary evidence of citizenship from individuals who have declared, under section 1137(d) of the Act, that the individual is a citizen of the United States unless the individual is subject to a statutory exemption from this requirement.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, we are required to provide 30-day notice in the **Federal Register** and solicit public comment when a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs).

Citizenship and Alienage (§ 435.406)

Section 435.406 requires States to obtain a declaration signed under penalty of perjury from every applicant for Medicaid that the applicant is a citizen or national of the United States or an alien in a satisfactory immigration status, and require the individual to provide acceptable documentary evidence to verify the declaration. (§ 435.407 describes the types of acceptable documentary evidence of citizenship.)

An individual should ordinarily be required to submit evidence of citizenship once unless the State receives evidence that evidence previously relied upon may be incorrect. States must maintain copies of that evidence in the case file or database.

We estimate it would take an individual 10 minutes to acquire and provide to the State acceptable documentary evidence and to verify the declaration.

We estimate it will take each State 5 minutes to obtain acceptable documentation, verify citizenship and maintain current records on each individual.

Citizenship and Alienage (§ 436.406)

Sections 436.406 and 436.407 apply to Guam, Puerto Rico, and the Virgin Islands and are the corresponding sections to the regulations at § 435.406 and § 435.407. An individual should ordinarily be required to submit evidence of citizenship once unless the State receives evidence that evidence previously relied upon may be incorrect. States must maintain copies of that evidence in the individual's case file.

We estimate it would take an individual 10 minutes to acquire and provide to the State acceptable documentary evidence and to verify the declaration.

We estimate it will take each State 5 minutes to obtain acceptable documentation, verify citizenship and maintain current records on each individual.

We have submitted a copy of this interim final rule with comment period to OMB for its review of the information collection requirements. A notice will be published in the **Federal Register** when we receive approval.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

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; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Katherine T. Astrich, CMS Desk Officer, CMS–2257–IFC, katherine_T._astrich@omb.eop.gov. Fax (202) 395–6974.

IV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the **DATES** section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

V. Waiver of Notice of Proposed Rulemaking and the 30-Day Delay in the Effective Date

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule in accordance with the Administrative Procedure Act (APA) as codified in 5 U.S.C. 553(b). The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

The regulation is required as a result of the enactment of the DRA, section

6036. The statutory effective date is July 1, 2006. Section 1903(x)(3)(C)(v) of the Act allows for the Secretary to identify additional documentary evidence of citizenship beyond that contained in section 1903(x). States would not be required to accept such other forms of documentation beyond that contained in the law without regulation. Because delaying the implementation of this regulation to permit notice and comment could result in the most frail and vulnerable citizens, including the very elderly in nursing homes and the chronically mentally ill, being unable to demonstrate their citizenship and losing access to Medicaid, we find that good cause exists to waive this requirement. The attendant delay would be contrary to public interest.

Publication of an interim final rule with comment period will provide States with the strongest legal basis for accepting alternative forms of documentary evidence showing that a Medicaid applicant or recipient is a citizen of the United States.

In addition, we ordinarily provide a 30-day delay in the effective date of the provisions of an interim final rule with comment period. The APA as codified in *5 U.S.C. 553(d)* ordinarily requires a 30-day delay in the effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the finding and its reasons in the rule issued.

The impending statutory implementation date of July 1, 2006 prevents timely publication of guidance to permit documents in addition to those listed in section 1903(x) of the Act as added by section 6036 the Deficit Reduction Act of 2005 (Pub. L. 109–171) to be used when any of the statutory documents is not available. It is necessary for the Secretary to identify additional documentary evidence of citizenship beyond that contained in section 6036 in order to prevent Medicaid eligible citizens lacking the documents identified in statute from being terminated. Without prompt publication of a rule and without a July 1, 2006 implementation date, States will not have authority to employ additional documentary evidence beyond that contained in the law. Such additional documentary evidence that the Secretary is authorized to permit States to use is necessary to prevent loss of Medicaid eligibility when a Medicaid eligible individual lacks one of the documents listed in statute. Because delaying the effective date of this regulation by 30 days could result in the most frail and vulnerable citizens, including the very elderly in nursing homes and the chronically mentally ill, being unable to demonstrate their citizenship and losing access to Medicaid, we find that good cause exists to waive this requirement. The attendant delay would be contrary to public interest.

VI. Regulatory Impact Statement

[If you choose to comment on issues in this section, please include the caption "Regulatory Impact Statement" at the beginning of your comments.]

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). It is assumed that Medicaid enrollees who are citizens would eventually provide proof of that fact, and that the savings would come from those who are truly in the country illegally. Consequently, the level of Federal savings from this provision is expected to be under $70 million, and State savings under $50 million, per year over the next 5 years. Therefore, this rule does not reach the economic threshold and thus is not considered a major rule.

The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $6 million to $29 million in any 1 year. Individuals and States are not included in the definition of a small entity. We are not preparing an analysis for the RFA because we have determined that this rule will not have a significant economic impact on a substantial number of small entities.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Core-Based Statistical Area and has fewer than 100 beds. We are not preparing an analysis for section 1102(b) of the Act because we have determined that this rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $120 million. This rule will have no consequential effect on State, local, or tribal governments or on the private sector.

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule (and subsequent final rule) that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has federalism implications. Although each State is responsible for establishing its own procedures for reviewing the documentation, several States have already been reviewing these documents. For these States, there will be little or no added burden. There will also be no additional burden for the millions of individuals enrolled in Medicare who would be exempt. In addition, for States that provide Medicaid eligibility for all SSI recipients, there will be no additional burden. For the other States, if they verify citizenship and identity of individuals receiving SSI through the existing data match with SSA, we anticipate little or no added burden with respect to those individuals. In the future, when additional data matches are available the burden would continue to be minimized for other groups of Medicaid eligible individuals.

Finally, with respect to those States that elect to review documents through the routine eligibility and redetermination process, we recognize there will be some increased burden on eligibility workers. However, the Medicaid eligibility and redetermination process is ordinarily conducted by skilled interviewers who are trained and skilled in the review of

documents related to income and identification; therefore, we do not anticipate that these added requirements will overburden the eligibility process.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 435

Aid to Families with Dependent Children, Grant programs-health, Medicaid, Reporting and recordkeeping requirements, Supplemental Security Income (SSI), Wages.

42 CFR Part 436

Aid to Families with Dependent Children, Grant programs-health, Guam, Medicaid, Puerto Rico, Virgin Islands.

42 CFR Part 440

Grant programs-health, Medicaid.

42 CFR Part 441

Aged, Family planning, Grant programs-health, Infants and children, Medicaid, Penalties, Reporting and recordkeeping requirement.

42 CFR Part 457

Administrative practice and procedure, Grant programs-health, Health insurance, Reporting and recordkeeping requirements.

42 CFR Part 483

Grant programs-health, Health facilities, Health professions, Health records, Medicaid, Medicare, Nursing homes, Nutrition, Reporting and recordkeeping requirements, Safety.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as set forth below:

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

■ 1. The authority citation for part 435 continues to read as follows:

Authority: Section 1102 of the Social Security Act (42 U.S.C. 1302).

■ 2. In § 435.403, in paragraph (b), "§ 435.1009 of this chapter" is revised to read § 435.1010."

■ 3. Section 435.406 is amended by—
■ A. Revising paragraph (a)(1).
■ B. Revising paragraph (a)(2).
■ C. Removing paragraphs (a)(3) and (a)(4).
■ D. Removing paragraph (b).
■ E. Redesignating paragraph (c) as paragraph (b).
■ F. Removing paragraph (d).

The revisions read as follows:

§ 435.406 Citizenship and alienage.

(a) * * *

(1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and

(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.

(iii) An individual for purposes of the citizenship requirement is a Medicaid applicant or recipient or an individual receiving any services under a section 1115 demonstration for which States receive Federal financial participation in their expenditures as though they were medical assistance, for example, family planning demonstrations or Medicaid demonstrations.

(iv) Individuals must declare their citizenship and the State must document the individual's citizenship in the individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.

(2) Qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

* * * * *

■ 4. A new § 435.407 is added to read as follows:

§ 435.407 Types of acceptable documentary evidence of citizenship.

(a) *Primary evidence of citizenship and identity.* The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:

(1) *A U.S. passport.* The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. **Note:** Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

(2) *A Certificate of Naturalization (DHS Forms N–550 or N–570.)* Department of Homeland Security issues for naturalization.

(3) *A Certificate of U.S. Citizenship (DHS Forms N–560 or N–561.)* Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

(4) A valid State-issued driver's license, but only if the State issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. (This provision is not effective until such time as a State makes providing evidence of citizenship a condition of issuing a driver's license and evidence that the license holder is a citizen is included on the license or in a system of records available to the Medicaid agency. The State must ensure that the process complies with this statutory provision in section 6036 of the Deficit Reduction Act of 2005. CMS will monitor compliance of States implementing this provision.); or

(5) At the State's option, for States which do not provide Medicaid to individuals by virtue of their receiving SSI, a State match with the State Data Exchange for Supplementary Security Income recipients. The statute gives the Secretary authority to establish other acceptable forms of citizenship documentation. SSA documents citizenship and identity for SSI applicants and recipients and includes such information in the database provided to the States.

(b) *Secondary evidence of citizenship.* If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or recipient should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.

(1) *A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI*

local time)). A State, at its option, may use a cross match with a State vital statistics agency to document a birth record. The birth record document may be issued by the State, Commonwealth, Territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. **Note:** If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico*:

(A) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or

(B) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

(ii) *U.S. Virgin Islands*:

(A) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or

(B) The applicant's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

(C) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

(iii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI))*:

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

(C) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

(D) **Note:** If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) *A Certification of Report of Birth (DS–1350).* The Department of State issues a DS–1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS–240. When the birth was recorded as a Consular Report of Birth (FS–240), certified copies of the Certification of Report of Birth Abroad (DS–1350) can be issued by the Department of State in Washington, DC. The DS–1350 contains the same information as that on the current version of Consular Report of Birth FS–240. The DS–1350 is not issued outside the U.S.

(3) *A Report of Birth Abroad of a U.S. Citizen (Form FS–240).* The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

(4) *A Certification of birth issued by the Department of State (Form FS–545 or DS–1350).* Before November 1, 1990, Department of State consulates also issued Form FS–545 along with the prior version of the FS–240. In 1990, U.S. consulates ceased to issue Form FS–545. Treat an FS–545 the same as the DS–1350.

(5) *A U.S. Citizen I.D. card.* (This form was issued as Form I–197 until the 1980's by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I–97.) INS issued the I–179 from 1960 until 1973. It revised the form and renumbered it as Form I–197. INS issued the I–197 from 1973 until April 7, 1983. INS issued Form I–179 and I–197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

(6) *A Northern Mariana Identification Card (I–873).* (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I–873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

(7) *An American Indian Card (I–872) issued by the Department of Homeland Security with the classification code "KIC."* (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the United States/Mexican border.) DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.

(8) *A final adoption decree showing the child's name and U.S. place of birth.* The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

(9) *Evidence of U.S. Civil Service employment before June 1, 1976.* The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

(10) *U.S. Military Record showing a U.S. place of birth.* The document must show a U.S. place of birth (for example a DD–214 or similar official document showing a U.S. place of birth.)

(c) *Third level evidence of citizenship.* Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence may be used only when primary evidence cannot be obtained within the State's reasonable opportunity period, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:

(1) *Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a*

U.S. place of birth. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Do not accept a souvenir "birth certificate" issued by the hospital. Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.

(2) *Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date and that indicates a U.S. place of birth.* Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(d) *Fourth level evidence of citizenship.* Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section.

(1) *Federal or State census record showing U.S. citizenship or a U.S. place of birth.* (Generally for persons born 1900 through 1950.) The census record must also show the applicant's age. **Note:** Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC–600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.

(2) *One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid.* This document must be one of the following and show a U.S. place of birth:

(i) Seneca Indian tribal census record.

(ii) Bureau of Indian Affairs tribal census records of the Navajo Indians.

(iii) U.S. State Vital Statistics official notification of birth registration.

(iv) An amended U.S. public birth record that is amended more than 5 years after the person's birth.

(v) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) *Institutional admission papers from a nursing facility, skilled care facility or other institution.* Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(4) *Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. **Note:** An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. **Note:** For children under 16 the document must have been created near the time of birth or 5 years before the date of application.

(5) *Written affidavit.* Affidavits should ONLY be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit).

(ii) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity.

(iv) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

(v) The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.

(vi) The affidavits must be signed under penalty of perjury.

(e) *Evidence of identity.* The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

(2) School identification card with a photograph of the individual.

(3) U.S. military card or draft record.

(4) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses.

(5) Military dependent's identification card.

(6) Native American Tribal document.

(7) U.S. Coast Guard Merchant Mariner card.

(8) Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).

(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.

(ii) School identification card with a photograph of the individual.

(iii) U.S. military card or draft record.

(iv) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses.

(v) Military dependent's identification card.

(vi) Native American Tribal document.

(vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(8): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity.

(9) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.

(10) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.

(f) *Special identity rules for children.* For children under 16, school records

may include nursery or daycare records. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(g) *Special populations needing assistance.* States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.

(h) *Documentary evidence.*

(1) All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.

(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.

(3) States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office. States may accept original documents in person, by mail, or by a guardian or authorized representative.

(4) If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies.

(5) Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

(6) CMS requires that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition, in cooperation with other agencies of the Federal government, CMS encourages States to use automated capabilities to verify citizenship and identity of Medicaid applicants. Automated capabilities may fall within the computer matching provisions of the Privacy Act of 1974, and CMS will explore any implementation issues that may arise with respect to those requirements. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and documents to verify identity, and CMS will make available to States necessary information in this regard. States must ensure that all case records within this category will be so identified and made available to conduct these automated matches. CMS may also require States to match files for individuals who used first or second level documents to verify citizenship as well. CMS may provide further guidance to States with respect to actions required in a case of a negative match.

(i) *Record retention.* The State must retain documents in accordance with 45 CFR 74.53.

(j) *Reasonable opportunity to present satisfactory documentary evidence of citizenship.* 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.)

§ 435.408 [Removed]

■ 5. Section 435.408 is removed.

■ 6. Section 435.1002 is amended by revising paragraph (a) to read as follows:

§ 435.1002 FFP for services.

(a) Except for the limitations and conditions specified in § 435.1007, §35.1008, § 435.1009, and § 438.814 of this chapter, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

* * * * *

§ 435.1008–§ 435.1011 [Redesignated]

■ 7. Sections 435.1008 through 435.1011 are redesignated as § 435.1009 through § 435.1012, respectively. Newly redesignated § 435.1011 and § 435.1012 are under the undesignated heading "Requirements for State Supplements."

■ 8. A new § 435.1008 is added to read as follows:

§ 435.1008 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

FFP will not be available to a State with respect to expenditures for medical assistance furnished to individuals unless the State has obtained satisfactory documentary evidence of citizenship or national status, as described in § 435.407 that complies with the requirements of section 1903(x) of the Act. This requirement does not apply with respect to individuals declaring themselves to be citizens or nationals who are eligible for medical assistance and who are either entitled to benefits or enrolled in any parts of the Medicare program under title XVIII of the Social Security Act, or on the basis of receiving supplemental security income benefits under title XVI of the Act.

■ 9. In newly redesignated § 435.1009, in paragraph (a)(1), "§ 435.1009" is revised to read "§ 435.1010."

PART 436—ELIGIBILITY IN GUAM, PUERTO RICO, AND THE VIRGIN ISLANDS

■ 10. The authority citation for part 436 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 436.406 [Amended]

■ 11. In § 436.403, paragraph (b), "§ 435.1009 of this chapter" is revised to read "§ 435.1010 of this chapter."

■ 12. Section 436.406 is amended by—

■ A. Revising paragraph (a)(1).

■ B. Revising paragraph (a)(2).

■ C. Removing paragraphs (a)(3) and (a)(4).

■ D. Removing paragraph (b).

■ E. Redesignating paragraph (c) as paragraph (b).

■ F. Removing paragraph (d).

The revisions read as follows:

§ 436.406 Citizenship and alienage.

(a) * * *

(1) Citizens: (i) Under a declaration required by section 1137(d) of the Act that the individual is a citizen or national of the United States; and

(ii) The individual has provided satisfactory documentary evidence of citizenship or national status, as described in § 435.407.

(iii) An individual for purposes of the citizenship requirement is a Medicaid applicant or recipient or an individual receiving any services under a section 1115 demonstration for which States receive Federal financial participation

in their expenditures as though they were medical assistance, for example, family planning demonstrations or Medicaid demonstrations.

(iv) Individuals must declare their citizenship and the State must document an individual's eligibility file on initial applications and initial redeterminations effective July 1, 2006.

(2) Qualified aliens as described in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) who have provided satisfactory documentary evidence of Qualified Alien status, which status has been verified with the Department of Homeland Security (DHS) under a declaration required by section 1137(d) of the Act that the applicant or recipient is an alien in a satisfactory immigration status.

* * * * *

■ 13. A new § 436.407 is added to read as follows:

§ 436.407 Types of acceptable documentary evidence of citizenship.

(a) *Primary evidence of citizenship and identity.* The following evidence must be accepted as satisfactory documentary evidence of both identity and citizenship:

(1) *A U.S. passport.* The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. **Note:** Spouses and children were sometimes included on one passport through 1980. U.S. passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exception: Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.

(2) *A Certificate of Naturalization (DHS Forms N–550 or N–570.)* Department of Homeland Security issues for naturalization.

(3) *A Certificate of U.S. Citizenship (DHS Forms N–560 or N–561.)* Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

(4) A valid State-issued driver's license, but only if the State issuing the license requires proof of U.S. citizenship before issuance of such license or obtains a social security number from the applicant and verifies before certification that such number is valid and assigned to the applicant who is a citizen. (This provision is not effective until such time as a State makes providing evidence of citizenship a condition of issuing a driver's license and evidence that the license holder is a citizen is included on the license or in a system of records available to the Medicaid agency. States must ensure that the process complies with this statutory provision in section 6036 of the Deficit Reduction Act of 2005. CMS will monitor compliance of States implementing this provision.); or

(b) *Secondary evidence of citizenship.* If primary evidence from the list in paragraph (a) of this section is unavailable, an applicant or recipient should provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship and satisfactory documentary evidence from paragraph (e) of this section to establish identity, in accordance with the rules specified in this section.

(1) *A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986 (NMI local time)).* A State, at its option, may use a cross match with a State vital statistics agency to document a birth record. The birth record document may be issued by the State, Commonwealth, Territory or local jurisdiction. It must have been issued before the person was 5 years of age. An amended birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship.

Note: If the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on certain dates listed for each of the territories. The following will establish U.S. citizenship for collectively naturalized individuals:

(i) *Puerto Rico:*

(A) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; or

(B) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

(ii) *U.S. Virgin Islands:*

(A) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; or

(B) The applicant's statement indicating resident in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

(C) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

(iii) *Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):*

(A) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

(B) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

(C) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

(D) **Note:** If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a U.S. citizen.

(2) *A Certification of Report of Birth (DS–1350).* The Department of State issues a DS–1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS–240. When the birth was recorded as a Consular Report of Birth (FS–240), certified copies of the Certification of Report of Birth Abroad (DS–1350) can be issued by the Department of State in Washington, DC. The DS–1350 contains the same information as that on the current version of Consular Report of Birth FS–240. The DS–1350 is not issued outside the U.S.

(3) *A Report of Birth Abroad of a U.S. Citizen (Form FS–240).* The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American

consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

(4) *A Certification of birth issued by the Department of State (Form FS–545 or DS–1350).* Before November 1, 1990, Department of State consulates also issued Form FS–545 along with the prior version of the FS–240. In 1990, U.S. consulates ceased to issue Form FS–545. Treat an FS–545 the same as the DS–1350.

(5) *A U.S. Citizen I.D. card.* (This form was issued as Form I–197 until the 1980's by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I–97.) INS issued the I–179 from 1960 until 1973. It revised the form and renumbered it as Form I–197. INS issued the I–197 from 1973 until April 7, 1983. INS issued Form I–179 and I–197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

(6) *A Northern Mariana Identification Card* (I–873). (Issued by the DHS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.) The former Immigration and Naturalization Service (INS) issued the I–873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

(7) *An American Indian Card (I–872) issued by the Department of Homeland Security with the classification code "KIC."* (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the United States/Mexican border.) DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship

(8) *A final adoption decree showing the child's name and U.S. place of birth.* The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized and the State in which the child was born will not release a birth certificate prior to final adoption, a statement from a State approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

(9) Evidence of U.S. Civil Service employment before June 1, 1976. The document must show employment by the U.S. government before June 1, 1976. Individuals employed by the U.S. Civil Service prior to June 1, 1976 had to be U.S. citizens.

(10) U.S. Military Record showing a U.S. place of birth. T he document must show a U.S. place of birth (for example a DD–214 or similar official document showing a U.S. place of birth.)

(c) *Third level evidence of citizenship.* Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence may be used only when primary evidence cannot be obtained within the State's reasonable opportunity period, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from paragraph (e) of this section to establish identity must also be presented:

(1) *Extract of a hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before the initial application date and that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Do not accept a souvenir "birth certificate" issued by the hospital.

Note: For children under 16 the document must have been created near the time of birth or 5 years before the date of application.

(2) *Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date that indicates a U.S. place of birth.* Life or health insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(d) *Fourth level evidence of citizenship.* Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section.

(1) *Federal or State census record showing U.S. citizenship or a U.S. place of birth.* (Generally for persons born 1900 through 1950.) The census record must also show the applicant's age. **Note:** Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or State should complete a Form BC–600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.

(2) *One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid.* This document must be one of the following and show a U.S. place of birth:

(i) Seneca Indian tribal census.

(ii) Bureau of Indian Affairs tribal census records of the Navajo Indians.

(iii) U.S. State Vital Statistics official notification of birth registration.

(iv) An amended U.S. public birth record that is amended more than 5 years after the person's birth

(v) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) *Institutional admission papers from a nursing facility, skilled care facility or other institution.* Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

(4) *Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth.* (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. **Note:** An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. **Note:** For children under 16 the document must have been created near the time of birth or 5 years.

(5) *Written affidavit. Affidavits should ONLY be used in rare circumstances.* If the documentation requirement needs to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or

recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit).

(ii) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity.

(iv) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim or citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

(v) The State must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained.

(vi) The affidavits must be signed under penalty of perjury.

(e) *Evidence of identity.* The following documents may be accepted as proof of identity and must accompany a document establishing citizenship from the groups of documentary evidence of citizenship in the groups in paragraphs (b) through (d) of this section.

(1) *A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.*

(2) *School identification card with a photograph of the individual.*

(3) *U.S. military card or draft record.*

(4) *Identification card issued by the Federal, State, or local government with the same information included on driver's licenses.*

(5) *Military dependent's identification card.*

(6) *Native American Tribal document.*

(7) *U.S. Coast Guard Merchant Mariner card.*

(8) *Identity documents described in 8 CFR 274a.2(b)(1)(v)(B)(1).*

(i) Driver's license issued by State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.

(ii) School identification card with a photograph of the individual.

(iii) U.S. military card or draft record.

(iv) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses.

(v) Military dependent's identification card.

(vi) Native American Tribal document.

(vii) U.S. Coast Guard Merchant Mariner card.

Note to paragraph (e)(8): Exception: Do not accept a voter's registration card or Canadian driver's license as listed in 8 CFR 274a.2(b)(1)(v)(B)(1). CMS does not view these as reliable for identity.

(9) *Certificate of Degree of Indian Blood, or other U.S. American Indian/ Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual.* Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.

(10) At State option, a State may use a cross match with a Federal or State governmental, public assistance, law enforcement or corrections agency's data system to establish identity if the agency establishes and certifies true identity of individuals. Such agencies may include food stamps, child support, corrections, including juvenile detention, motor vehicle, or child protective services. The State Medicaid Agency is still responsible for assuring the accuracy of the identity determination.

(f) *Special identity rules for children.* For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding groups are available, an affidavit may be used. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(g) *Special populations needing assistance.* States must assist individuals to secure satisfactory documentary evidence of citizenship when because of incapacity of mind or body the individual would be unable to comply with the requirement to present satisfactory documentary evidence of citizenship in a timely manner and the individual lacks a representative to assist him or her.

(h) *Documentary evidence.*

(1) All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.

(2) States must maintain copies of citizenship and identification documents in the case record or electronic data base and make these copies available for compliance audits.

(3) States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office. States may accept original documents in person, by mail, or by a guardian or authorized representative.

(4) If documents are determined to be inconsistent with pre-existing information, are counterfeit, or altered, States should investigate for potential fraud and abuse, including but not limited to, referral to the appropriate State and Federal law enforcement agencies.

(5) Presentation of documentary evidence of citizenship is a one time activity; once a person's citizenship is documented and recorded in a State database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship. The State need only check its databases to verify that the individual already established citizenship.

(6) CMS requires that as a check against fraud, using currently available automated capabilities, States will conduct a match of the applicant's name against the corresponding Social Security number that was provided. In addition, in cooperation with other agencies of the Federal government, CMS encourages States to use automated capabilities to verify citizenship and identity of Medicaid applicants. Automated capabilities may fall within the computer matching provisions of the Privacy Act of 1974, and CMS will explore any implementation issues that may arise with respect to those requirements. When these capabilities become available, States will be required to match files for individuals who used third or fourth tier documents to verify citizenship and documents to verify identity, and CMS will make available to States necessary information in this regard. States must ensure that all case records within this category will be so identified and made available to conduct these automated matches. CMS may also require States to match files for individuals who used first or second level documents to verify citizenship as well. CMS may provide further guidance to States with respect to actions required in a case of a negative match.

(i) *Record retention.* The State must retain documents in accordance with 45 CFR 74.53.

(j) *Reasonable opportunity to present satisfactory documentary evidence of citizenship.* 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 of this chapter.)

§ 436.408 [Removed and reserved]

■ 14. Section 436.408 is removed and reserved.

§ 436.1004–§ 436.1005 [Redesignated]

■ 15. Sections 436.1004 and § 436.1005 are redesignated as § 436.1005 and § 436.1006, respectively.

■ 16. New section 436.1004 is added to read as follows:

§ 436.1004 FFP in expenditures for medical assistance for individuals who have declared United States citizenship or nationality under section 1137(d) of the Act and with respect to whom the State has not documented citizenship and identity.

FFP will not be available to a State with respect to expenditures for medical assistance furnished to individuals unless the State has obtained satisfactory documentary evidence of citizenship or national status, as described in § 436.407 that complies with the requirements of section 1903(x) of the Act. This requirement does not apply with respect to individuals declaring themselves to be citizens or nationals who are eligible for medical assistance and who are either entitled to benefits or enrolled in any parts of the Medicare program under title XVIII of the Social Security Act.

Technical Amendments

§ 436.1005 [Amended]

■ 17. In newly redesignating § 436.1005, in paragraph (a)(1), "§ 435.1009" is revised to read "§ 435.1010 of this chapter."

§ 436.1006 [Amended]

■ 18. In newly redesignating § 436.1006, "§ 435.1009 of this subchapter" is revised to read "§ 435.1010 of this chapter."

PART 440—SERVICES: GENERAL PROVISIONS

■ 19. The authority citation for part 440 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 440.2 [Amended]

■ 20. In § 440.2, in paragraph (a), in the definition of "Patient," "§ 435.1009 of this subchapter" is revised to read "§ 435.1010 of this chapter."

§ 440.140 [Amended]

■ 21. In § 440.140, in paragraph (b), "§ 435.1009 of this chapter" is revised to read "§ 435.1010 of this chapter."

§ 440.180 [Amended]

■ 22. In § 440.180, in paragraph (d)(2)(i), "§ 435.1008(a)(2) of this subchapter" is revised to read "§ 435.1009(a)(2) of this chapter."

§ 440.185 [Amended]

■ 23. In § 440.185, in paragraph (b), "§ 435.1009" is revised to read "§ 435.1010 of this chapter."

PART 441—SERVICES: REQUIREMENTS AND LIMITS APPLICABLE TO SPECIFIC SERVICES

■ 24. The authority citation for part 441 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 441.13 [Amended]

■ 25. In § 441.13, in paragraph (a)(1), § 435.1009 of this subchapter" is revised to read "§ 435.1010 of this chapter."

PART 457—ALLOTMENTS AND GRANTS TO STATES

■ 26. The authority citation for part 457 continues to read as follows:

Authority: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

§ 457.310 [Amended]

■ 27. In § 457.310, in paragraphs (c)(2)(i) and (c)(2)(ii), "§ 435.1009 of this chapter" is revised to read § 435.1010 of this chapter."

PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES

■ 28. The authority citation for part 483 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 483.5 [Amended]

■ 29. In § 483.5, in paragraph (a), "§ 435.1009 of this chapter" is revised to read "§ 435.1010 of this chapter."

§ 483.20 [Amended]

■ 30. In § 483.20, in paragraph (m)(2)(ii), "42 CFR 435.1009" is revised to read § 435.1010 of this chapter."

§ 483.102 [Amended]

■ 31. In § 483.102, in paragraph (b)(3)(ii), "§ 435.1009 of this chapter" is revised to read "§ 435.1010 of this chapter."

§ 483.136 [Amended]

■ 32. In § 483.136, in paragraph (a), "§§ 435.1009 and 483.440 of this chapter" is revised to read "§ 435.1010 of this chapter and § 483.440."

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: June 23, 2006.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Approved: June 30, 2006.

Michael O. Leavitt,

Secretary.

[FR Doc. 06–6033 Filed 7–6–06; 5:00 pm]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 15

[ET Docket No. 03–122; FCC 06–96]

Unlicensed Devices in the 5 GHz Band

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document addresses petitions for reconsideration and clarification of the Commission's rules for 5 GHz U–NII devices adopted in the *Report and Order* in ET Docket No. 03–122 and revises the measurement procedures for certifying U–NII devices in the 5 GHz band. Our action will ensure that all applications for equipment certification of U–NII devices comply with the U–NII requirements.

DATES: Effective August 11, 2006.

FOR FURTHER INFORMATION CONTACT: Shameeka Hunt, Policy and Rules Division, Office of Engineering and Technology, (202) 418–2062, e-mail: *Shameeka.Hunt@fcc.gov.*

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Memorandum Opinion and Order*, ET Docket No. 03–122, FCC 06–96, adopted June 29, 2006, and released June 30, 2006. The full text of this document is available for inspection and copying during regular business hours in the FCC Reference Center (CY–A257) 445 12th Street, SW., Washington, DC 20554. The complete text of this document also may be purchased from the Commission's copy contractor, Best Copy and Printing Inc., Portals II, 445 12th Street, SW., Room CY–B402, Washington, DC 20554; telephone (202) 488–5300; fax (202) 488–5563; e-mail *FCC@BCPIWEB.COM.*

NATIONAL ASSOCIATION of PUBLIC HOSPITALS and HEALTH SYSTEMS
1301 PENNSYLVANIA AVENUE, NW, SUITE 950, WASHINGTON DC 20004 | 202.585.0100 | FAX 202.585.0101

August 11, 2006

Via Courier

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Re: Comments for CMS-2257-IFC
Medicaid Citizenship Verification Interim Final Rule
71 Fed. Reg. 29214 (July 12, 2006)

Dear Dr. McClellan:

The National Association of Public Hospitals and Health Systems ("NAPH") is pleased to submit the following comments on the interim final rule[1] implementing the citizenship verification requirements under section 6036 of the Deficit Reduction Act of 2005 ("DRA," Pub. L. No. 109-171).[2] NAPH represents more than 100 of America's safety net hospitals and health systems. Our mission is to provide healthcare services to all individuals, regardless of insurance status or ability to pay.

NAPH member hospitals are on the front lines treating this country's most vulnerable populations and are extremely concerned about the impact that the new Medicaid citizenship verification requirements will have on their ability to care for low-income patients and, more importantly, on the ability of their patients, who are U.S. citizens, to obtain the Medicaid coverage to which they are entitled. Preliminarily, our membership has indicated that a very significant portion of otherwise eligible Medicaid recipients will likely be unable to meet these new verification requirements.

NAPH requested a preliminary study by Chamberlin Edmonds, a firm that assists NAPH members and others determine Medicaid eligibility for mostly disabled patients. Chamberlin Edmonds analyzed a one-week sample of potentially Medicaid eligible, disabled patients from its client hospitals and determined that 54 percent of patients could not provide the documentation

[1] Hereinafter "Interim Rule."
[2] Hereinafter "Section 6036."

required by the Centers for Medicare & Medicaid Services ("CMS") in the final rule to verify citizenship.[3] **Only 7 percent of patients could provide documentation from Group 1, which effectively consists of a U.S. passport, certificate of naturalization or a certificate of citizenship. The sample excluded patients that were not potentially Medicaid eligible and also excluded patients that were eligible for Section 1011 payments, emergency Medicaid or had a foreign place of birth.**

While our members strongly support thorough and complete verification of all Medicaid eligibility requirements, results like these indicate that the verification standards in the Interim Rule will impose a substantial burden and result in the denial of Medicaid benefits to eligible U.S. citizens. We therefore urge consideration of the following comments as CMS finalizes its regulations on this issue.

In summary, our recommendations are as follows:

- CMS should remove arbitrary restrictions placed on the use of certain documents, including: the requirement that affiants have "personal knowledge" of the events establishing an applicant's or recipient's claim of citizenship, the prohibition on the use of affidavits by naturalized U.S. citizens, and the five-year restriction on the use of certain documents;

- CMS should make it easier for U.S. citizens to obtain necessary documentation by clarifying the ability of states to claim federal financial participation ("FFP") for costs associated with obtaining documents on behalf of Medicaid recipients or applicants and the ability of providers to obtain documents on behalf of Medicaid recipients or applicants;

- CMS should broaden its definition of "special populations needing assistance" to include a disability that falls short of complete incapacitation, displacement due to natural disaster (such as Hurricane Katrina), and homelessness;

- The final rules should ensure that new applicants who are otherwise Medicaid eligible are not forced to wait for coverage until their citizenship verification has been finalized;

- CMS should require states to utilize electronic data matches as a way to speed compliance with citizenship verification and to lessen the burden on Medicaid recipients and applicants; and

- CMS should ensure that Title IV-E foster children and newborn infants are not denied Medicaid coverage.

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[3] Chamberlin Edmonds surveyed a total of 980 self pay patients in a one-week period. Data cited represent a smaller subset of those sampled – 318 patients – who were likely Medicaid eligible.

We appreciate the opportunity to submit these comments for review by CMS, and are committed to maintaining the long-term integrity of the Medicaid program. We look forward to working with you on this matter. If you have any questions, please feel free to contact Kate Spaziani at NAPH Counsel Powell Goldstein LLP, at 202-624-3912 or kspaziani@pogolaw.com.

Sincerely,

Larry S. Gage
President

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NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS COMMENTS ON INTERIM FINAL RULE REGARDING CITIZENSHIP VERIFICATION DOCUMENTATION REQUIREMENTS

Comments for CMS-2257-IFC
Medicaid Citizenship Verification Interim Final Rule
71 Fed. Reg. 29214 (July 12, 2006)

A. CMS should remove arbitrary restrictions placed on the use of certain documents.

NAPH is concerned that under the Interim Rule,[1] the new 42 C.F.R. § 435.407, "Types of acceptable documentary evidence of citizenship," places unnecessary restrictions on the use of certain documents. The following restrictions included in the Interim Rule are not required by the statutory language of section 6036 of the Deficit Reduction Act of 2005 ("DRA," Pub. L. No. 109-171)[2] and will result in the denial of Medicaid benefits for U.S. citizens:

1. CMS should require that affiants have "knowledge," not "personal knowledge," of the event(s) establishing the applicant's or recipient's claim of citizenship."[3]

The Interim Rule requires that affiants have "personal knowledge" of the event(s) establishing the applicant's or recipient's claim of citizenship. "Personal knowledge" is defined legally as "knowledge gained through firsthand observation or experience."[4] We believe that this standard is unreasonably high given that many Medicaid applicants may not have relationships with individuals that have "personal knowledge" of the events that establish a claim of citizenship. For example, it is highly unlikely that a child born in the U.S. and placed in state custody through the foster care program would have a relationship with a parent or other individual with personal knowledge of their birth. A more preferable alternative would be to simply require that the affiant have "knowledge" of the basis for an applicant's claim of citizenship, defined as an "awareness or understanding of a fact or circumstance; [or] a state of mind in which a person has no substantial doubt about the existence of a fact."[5] NAPH urges CMS to allow the affidavit of an individual with "knowledge" of the event(s) establishing an applicant's claim of citizenship to satisfy verification requirements under Section 6036.

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[1] Hereinafter "Interim Rule."
[2] Hereinafter "Section 6036."
[3] Interim Rule at 39224.
[4] Black's Law Dictionary 888 (8th ed. 2004).
[5] Id.

2. CMS should permit applicants born outside the United States to utilize affidavits as a form of documentation establishing proof of citizenship.[6]

In specifying which documents may be used to verify citizenship, the Interim Rule precludes Medicaid recipients or applicants born outside the United States from using an affidavit to establish proof of citizenship.[7] This restriction deprives naturalized U.S. citizens of a critical form of documentation made available under the Rule to U.S.-born citizens. We believe this policy not only raises constitutional equal protection concerns because it creates a distinction based upon national origin, but also appears arbitrary in light of the very intent behind the citizenship verification requirements. Indeed, it seems more likely that a naturalized citizen, rather than a U.S.-born citizen, could utilize the affidavit option as a reliable, useful form of citizenship documentation. The probability that two affiants would be able to testify about, for example, their attendance at a naturalization ceremony seems just as high, if not higher, than their ability to testify about their presence at an individual's birth. Preventing naturalized U.S. citizens from taking advantage of this form of documentation therefore appears arbitrary.

Use of an affidavit would, of course, remain below naturalization certificates in CMS' order of preferred documentation. However, we strongly urge CMS to reconsider the distinctions it has drawn among naturalized and U.S.-born citizens and to permit the use of affidavits as an acceptable means of documentation for both groups.

3. CMS should eliminate the prohibition on states accepting certain documents (such as extracts of hospital records, insurance records, certain tribal records, physician statements, and amended U.S. public birth records) not created at least five years before the individual's application for Medicaid.[8]

The Interim Rule requires that certain documents (such as extracts of hospital records, insurance records, certain tribal records, physician statements, and amended U.S. public birth records) be created at least five years before an individual's application for Medicaid. This restriction is arbitrary, and specifically as it applies to birth certificates, contrary to the statutory language of Section 6036.

The application of the five year restriction under the Interim Rule in general – including birth certificates, hospital records, insurance records, tribal records, and physician statements – is an arbitrary limitation that will place an unacceptable and unnecessary burden on U.S. citizens. CMS has provided no basis for this restriction or any reasoning as to why documentation that is a minimum of five years old is any more worthy than more recent documentation.

Specifically with respect to birth certificates, Section 6036 expressly provides for the use of "[a] certificate of birth in the United States"[9] to establish citizenship status. Although the Secretary has discretion in identifying "Such ***other*** document (not described in subparagraph (B)(iv) as the Secretary may specify that provides proof of United States citizenship or

[6] Interim Rule at 39214.
[7] Id. at 39222, 39224.
[8] Id. at 39223-24.
[9] Section 6036(a)(2).

nationality,"[10] we do not believe that Section 6036 provides the Secretary with discretion to limit the permissibility of using a "certificate of birth" by imposing a five year restriction. Therefore, this restriction should be removed.

B. CMS should make it easier for U.S. citizens to obtain necessary documentation

1. CMS should clarify the ability of states to claim federal financial participation ("FFP") for costs associated with obtaining documents on behalf of Medicaid recipients or applicants.

In the Interim Rule, CMS provides that federal financial participation ("FFP") will be available "for State expenditures to carry out the provisions of section 1903(x) of the Act at the match rate for program administration."[11] However, this provision does not address the costs associated with Medicaid recipients and applicants obtaining necessary documentation. Given the very modest means of Medicaid recipients, the costs of acquiring official birth certificates, valid passports, and even a state-issued driver's license will likely represent a significant burden. Thus, it is critical that CMS clarify that FFP at the administrative match rate also is available to states for costs incurred when assisting Medicaid recipients and applicants to obtain necessary documentation. By definition, these are low-income individuals who are unlikely able to incur these costs.

A review of state-by-state requirements placed on individuals seeking to obtain certified copies of their birth certificates, an option under Tier 2 of the citizenship verification documentation hierarchy,[12] demonstrates the need for state assistance. Individuals face a myriad of hurdles including: fees, which generally range from $5 up to $30 for basic services, and additional costs for expedited service; long waiting periods for receipt by mail, during which time new applicants will go without Medicaid benefits under the new rule; different required forms of payment, including credit card, money order, and certified check; and even the need for an accompanying sworn, notarized statement. To encourage state assistance with this process and to prevent otherwise eligible U.S. citizens from being denied Medicaid benefits to which they are legal entitled, NAPH urges CMS to clarify that states may obtain FFP for costs incurred in helping Medicaid recipients and applicants obtain the necessary documentation.

2. CMS should clarify the ability of providers to obtain documents on behalf of Medicaid recipients or applicants.

Some providers, particularly safety net providers that might otherwise treat these individuals as uninsured, may wish to assist Medicaid recipients in obtaining necessary documentation to clarify U.S. citizen status for their patients. However, there is the possibility that CMS or the Office of the Inspector General ("OIG") could view this assistance by a provider as "remuneration" designed to influence an individual to receive benefits from a particular provider, in violation of the Civil Monetary Penalties statute. 42 U.S.C. § 1320a-7a(a)(5).

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[10] Id. (emphasis added).
[11] Interim Rule at 39217.
[12] Id. at 39218.

Clarification is necessary to ensure that providers are permitted to assist patients in documenting eligibility.

Providers may face other barriers related to the ability of third parties to access individuals' documentation. For example, it is our understanding that the Social Security Administration ("SSA") charges third parties additional fees for verification inquiries. We urge CMS to work with SSA to ensure that such fees are not charged to providers assisting U.S. citizens with citizenship verification. There appears to be precedence for the suspension of these fees, as we understand that SSA does not levy them on applicants for Social Security Income ("SSI") benefits.

Providers may also be prevented from assisting individuals in requesting copies of documents such as birth certificates, as some states prohibit their vital statistics agencies from releasing such documents to third parties. In finalizing the Interim Rule, CMS should urge states to reconsider this policy where providers are attempting to assist Medicaid applicants and recipients in complying with citizenship verification requirements.

C. CMS should broaden its definition of "special populations needing assistance" to include a disability that falls short of complete incapacitation, displacement due to natural disaster, and homelessness.

NAPH applauds the agency's revision of the previous aspirational provisions concerning state assistance for vulnerable populations to include new mandatory requirements under new 42 C.F.R. § 435.407.[13] The revision in the Interim Rule demonstrates CMS' recognition of the problems that many Medicaid recipients and applicants will have in producing necessary documentation. We urge CMS to expand upon this positive step to recognize the needs of a broader population of individuals than simply those "of incapacity of mind or body" who are without a representative.[14]

NAPH members care for significant numbers of low-income patients, with over 32 percent of our services provided to Medicaid recipients and over 24 percent provided to uninsured patients. As the healthcare providers who often care for these individuals, NAPH members witness the many challenges that face the Medicaid population on a daily basis. These challenges are not limited to "incapacity of mind or body," and include such things as: a disability that falls short of complete incapacitation; displacement due to natural disaster, such as Hurricane Katrina; and homelessness. NAPH urges CMS to provide states with the flexibility to further expand the category of "special populations needing assistance" in order to tailor assistance according to the needs of different communities.

D. The final rules should ensure that new applicants who are otherwise Medicaid eligible are not forced to wait for coverage until their citizenship verification has been finalized.

[13] Id. at 39225.
[14] Id.

CMS should revise the new 42 C.F.R. § 435.407(j) to ensure that eligible Medicaid applicants are not denied coverage while awaiting finalization of their compliance with citizenship verification.[15] Under current Medicaid law, legal immigrants must provide documentation to verify their immigration status "in a reasonable time period" in order to qualify for Medicaid. In addition, federal Medicaid law clarifies that States "may not delay, deny, reduce, or terminate the individual's eligibility for benefits under the program on the basis of the individual's immigration status until...a reasonable opportunity has been provided."[16] Thus, current Medicaid law ensures that during the reasonable time period that legal immigrants are verifying immigration status for Medicaid purposes they must receive Medicaid coverage.

In sharp contrast to these protections, the Interim Rule *requires* that states *withhold* coverage for new Medicaid beneficiaries until their immigration status has been verified. It is logically inconsistent that U.S. citizens seeking to comply with citizenship verification should be subject to harsher verification requirements than legal immigrants, and this requirement is not included in Section 6036. Under general rules of statutory construction, CMS should harmonize Section 6036 with other provisions within the Social Security Act.[17] Given that the new Section 6036 enhanced verification requirements are analogous to those that apply to legal immigrants,[18] CMS should equally apply those congressionally mandated protections available to U.S. citizens as well.

E. CMS should require states to utilize electronic data matches as a way to speed compliance with citizenship verification and to lessen the burden on Medicaid recipients and applicants.

NAPH commends CMS on its inclusion of certain electronic data matching options for states in the Interim Rule.[19] The availability of the State Data Exchange (SDX) and cross-matching with state vital statistics agencies is a significant improvement over previous agency guidance and an important step towards ensuring that no Medicaid eligible U.S. citizens lose coverage. NAPH urges CMS, however, go further by requiring states to do electronic data matching, by a date certain, instead of merely permitting them to utilize this resource.

Under the Interim Rule, CMS indicated that states may, "at their option," use cross matches with sources such as the SDX, vital statistics agencies, public assistance agencies, law enforcement entities, and corrections agencies.[20] Given the costs and obstacles associated with obtaining copies of necessary documentation, wide use of cross-matching would substantially reduce burdens facing Medicaid recipients and applicants while at the same time increase the accuracy and integrity of the verification process itself. NAPH urges CMS to require states to utilize electronic data matches as a way to speed compliance with citizenship verification and to lessen the burden on Medicaid recipients and applicants.

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[15] Id.
[16] See Social Security Act ("SSA") § 1137(d)(4).
[17] See e.g., Robinson v. Shell Oil Co, 117 S. Ct. 843 (U.S., 1997).
[18] See Social Security Act ("SSA") § 1137(d)(4).
[19] Interim Rule at 39216.
[20] Id. at 39216, 39224.

F. CMS should ensure that Title IV-E foster children and newborn infants are not denied Medicaid coverage.

In the Interim Rule, CMS provides that Title IV-E children receiving Medicaid are required to have in their Medicaid files both a declaration of citizenship and documentary evidence of that status.[21] This requirement is redundant, as citizenship status for Title IV-E children is currently conducted during the determination process establishing their eligibility for federal foster care assistance.[22] In addition to being unnecessary, the application of citizenship verification requirements to this highly vulnerable population of children appears at odds with the intent of Section 6036, which was premised on the need to protect the integrity of Medicaid from individuals seeking to unlawfully exploit it. There is no evidence that Congress considered foster children, who historically and almost uniformly receive Medicaid coverage, as a threat to the integrity of the program.

Similarly, CMS' requirement that documentation be presented at renewal for those U.S.-born infants whose births are covered under Medicaid is unnecessarily burdensome.[23] CMS should adopt a simplified documentation option allowing evidence of Medicaid payment for the birth of a newborn infant to be available to all U.S.-born infants, regardless of the citizenship status of their mothers.

NAPH urges CMS to adopt a new exemption to citizenship verification requirements for Title IV-E foster children, and to introduce a new documentation option for verifying the obvious U.S. citizenship status of newborn babies born in U.S. hospitals. Failure to do so would contradict both the spirit of the Medicaid program and the congressional intent underlying the citizenship verification requirement.

[21] Id. at 39216.
[22] See Administration for Children and Families, Child Welfare Policy Manual, § 8.4B.
[23] Interim Rule at 39216.

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. 29214 (July 12, 2006)

The 20 undersigned organizations are pleased to submit these comments on CMS's Interim Final Rule on the new Medicaid citizenship documentation requirement.

The American College of Nurse-Midwives represents some 7,000 certified nurse-midwives and certified midwives across the nation who care for women and their newborns.

The American Nurses Association (ANA) is the only full-service professional association representing the nation's registered nurses through its 54 constituent member organizations. ANA supports the availability and accessibility of affordable, quality health care for Medicaid beneficiaries.

The American Public Health Association (APHA) is the oldest, largest and most diverse organization of public health professionals in the world, dedicated to protecting all Americans, their families and communities from preventable, serious health threats and assuring community-based health promotion and disease prevention activities and preventive health services are universally accessible in the United States.

The Asian and Pacific Islander American Health Forum's mission is to enable Asian Americans and Pacific Islanders to attain the highest level of health and well being.

The Association of University Centers on Disabilities is a network of interdisciplinary Centers advancing policy and practice for and with individuals with developmental and other disabilities, their families, and communities.

The Epilepsy Foundation is the national voluntary health association solely dedicated to the welfare of the nearly 3 million people with epilepsy in the U.S. and their families. The Foundation works to ensure that people with seizures are able to participate in all life experiences and will prevent, control and cure epilepsy through research, education, advocacy and services.

Families USA is the national, non-profit, non-partisan organization for health care consumers. Our mission is to ensure that all Americans have access to high-quality, affordable health care. Families USA strongly supports comprehensive, affordable health insurance for all residents of this nation.

The National Alliance of State and Territorial AIDS Directors is a nonprofit national association of state health department HIV/AIDS program directors responsible for administering HIV/AIDS and viral hepatitis health care, prevention, education, and supportive services programs funded by state and federal governments. NASTAD is dedicated to reducing the incidence of HIV and viral hepatitis infection in the U.S. and its territories, providing comprehensive, compassionate, and quality care to all persons living with HIV/AIDS, and the development of responsible and compassionate public policies. NASTAD is a co-chair of the HIV Medicare and Medicaid Workgroup, a coalition of 73 national, state, and local AIDS advocacy organizations, community groups, healthcare providers, Medicaid and Medicare consumers, and other individual advocates. The Workgroup is committed to ensuring that people living with HIV/AIDS have access to appropriate, cost-effective health care and drug treatment.

NASOP is the Association of State Long-Term Care Ombudsmen. The programs its members administer provide ombudsman advocacy services to residents of long-term care facilities.

National Center for Law and Economic Justice is a national non-profit legal and policy advocacy organization that uses litigation, policy organizing, and support for grassroots organizing to ensure that all low-income people have access to critical public benefits and services, including Medicaid, for which they are eligible.

Established in 1994 in Washington, DC, The National Hispanic Medical Association is a non-profit representing licensed Hispanic physicians in the U.S. The mission of NHMA is to improve the health of Hispanics and other underserved.

The National Immigration Law Center (NILC) is dedicated to protecting and promoting the rights of low income immigrants and their family members.

The National Latino Council on Alcohol and Tobacco Prevention (LCAT) is a national, nonpartisan organization with a network of over 2,500 Latino community health advocates and experts concerned about access to health for members of our communities.

The National WIC Association, NWA, represents the 50 geographic state agencies, 37 Indian and Native American territory, trust and commonwealth state agencies and 2,200 local agencies that together provide WIC services to 8 million women, infants and children monthly through 10,000 WIC clinics nationwide. NWA is dedicated to providing leadership to the WIC Community in promoting quality nutrition services; advocating for services for all eligible women, infants and children; and assuring the sound and responsive management of the WIC Program.

The National Migrant and Seasonal Head Start Association (NMSHSA), a non profit 501(c) (3) organization, was incorporated in 2001 to be the voice for the children of migrant and seasonal farmworkers within the Head Start community and serves as the premier advocate for resources, the disseminator of information to the general public and to create partnerships to help member agencies provide quality comprehensive services to all farmworker children and their families.

Out of Many, One is a national multicultural advocacy network of organizations representing the five major racial/ethnic groups experiencing health disparities. OMO is committed to help attain health parity for communities of color. A primary focus is advocacy for racial/ethnic and language preference data as an essential requirement for achieving these goals.

Project Inform is a national HIV/AIDS healthcare and treatment advocacy organization based in San Francisco. It advocates for programs that provide quality care for people with HIV/AIDS, including Medicaid, Medicare, and the Ryan White CARE Act. Project Inform also organizes "PI Action", a national grassroots network of people affected by HIV/AIDS who communicate with their elected officials on key legislative and funding issues.

RESULTS is a nonprofit grassroots advocacy organization, committed to creating the political will to end hunger and the worst aspects of poverty. RESULTS is committed to individuals exercising their personal and political power by lobbying elected officials for effective solutions and key policies that affect hunger and poverty.

SHIRE is a national policy advocacy organization with deep community roots that focuses on the elimination of health disparities among communities of color. We work for attaining optimal health for all through advocacy, policy research and analysis, coalition-building, technical assistance and community demonstrations with policy implications.

USAction is dedicated to winning liberty and justice for all. They represent three million members in 34 affiliates, with statewide organizations in 24 states.

At least 42 million individuals who are already on Medicaid will be affected by this new documentation requirement. We are deeply concerned that many of these individuals, as well as the thousands of people who apply for Medicaid each year, will face the loss or denial of Medicaid coverage because they cannot meet the requirements of the Interim Final Regulation to prove their citizenship and/or identity.

Positive Aspects of the Rule

We commend CMS for ameliorating the impact of the new documentation requirement by:

1) Recognizing the "scrivener's error" in the statute and exempting individuals on SSI or Medicare from the new rule.
2) Allowing the use of the SDX and state vital records databases to cross-match citizenship records, as well as allowing states to use state and federal databases to conduct identity cross-matches.
3) Clarifying that the new citizenship documentation requirement does not apply to "presumptive eligibility" for pregnant women and children in Medicaid, and that states may continue to use this effective and important strategy for enrollment.

These important steps will alleviate the burden of the documentation requirement for millions of vulnerable citizens.

However, many aspects of the rule remain problematic and overly burdensome for Medicaid recipients and applicants.

Concerns about the Rule

435.407(a) Medicaid payment records for births in U.S. hospitals should suffice as proof of citizenship and identity for newborns.

According to the preamble to the rule, newborns who are born to mothers on Medicaid will have to provide citizenship documentation at their next renewal (newborns are categorically-eligible for one year if their mothers were categorically-eligible at the child's birth and would have continued to be eligible if they were still pregnant during this time). 71 Fed. Reg. at 39216. The preamble also states that newborns born to undocumented immigrants or legal immigrants within the 5-year bar must apply for Medicaid and provide citizenship documentation following their birth before they can get any coverage at all. 71 Fed. Reg. at 39216. Yet, in both situations, there is no question that these children are American citizens by virtue of their birth in U.S. hospitals. Moreover, the states have first-hand knowledge of the citizenship of these children because Medicaid paid for their births.

This policy is problematic because it creates additional paperwork and potential delays or loss of coverage for infants, many of whom will have immediate health care needs, especially for those children who must, under the regulations, show proof of citizenship in order to get Medicaid coverage at birth. It is unlikely that these children can prove citizenship through state vital record matches, because time delays and processing lags do not allow for vital records to be created immediately at time of birth. Other third or fourth tier documents may be used, but are problematic as well. The third tier hospital record created at time of birth may be difficult to obtain in a prompt manner. A medical record created near the time of birth could be used, but it may be just as difficult to obtain, and as a fourth tier document, it can only be used "in the rarest of circumstances." 71 Fed. Reg. at 39224.

The easiest way to solve this problem is to allow states to use Medicaid billing records of births it has paid for as proof of U.S. citizenship and identity. Children born in the U.S., whose births were paid for by Medicaid, should be able to get and keep Medicaid if they are otherwise eligible without the need for their families to provide any additional proof that they are citizens.

We urge CMS to amend 42 CFR 435.407(a) to add that a state Medicaid agency's record of payment for the birth of an individual in a U.S. hospital is primary documentary evidence of both citizenship and identity.

435.407(a)-(d) The document hierarchy established in the rule goes beyond the statutory requirements of the DRA.

The Interim Final Rule and June 9, 2006 State Medicaid Director letter establish a hierarchical structure for documents that individuals can use to prove citizenship. The documents are tiered according to their "reliability." 71 Fed. Reg. at 39218. Documents such as a U.S. passport or

Certificate of Naturalization are in the first tier and thus deemed more "reliable" than documents in Tiers 2, 3 and 4. The rule also requires states to obtain higher-level documentation where it is available, before moving on to documentation from a lower tier. 71 Fed. Reg. at 39222-39224.

While we are pleased that CMS has used the authority granted in the DRA expanded the list of documents that can be used to prove citizenship beyond those included in the statute, we are concerned that the hierarchy employed in the Interim Final Rule goes beyond the statutory requirements of Section 6036 of the DRA. The hierarchy will cause significant time delays for applicants and headaches for agency staff and beneficiaries and applicants as individuals attempt to demonstrate that they cannot get a higher tier document before moving to the subsequent tier. The hierarchy also makes little sense: If a fourth tier document eventually becomes sufficient proof for an individual, then why cannot it be sufficient documentation at the outset?

We urge CMS to amend 42 CFR 435.407(a)-(d) and eliminate the document hierarchy.

435.407(a) Native American tribal enrollment cards should be included in the list of documents to prove citizenship

The new rule and their four tier hierarchy of documents do not allow for Native American tribal identification documents to be used to prove U.S. citizenship,[1] although they may be used for identity purposes. The National Association of State Medicaid Directors has stated that the tribal enrollment process does a "thorough job of assuring that an individual was born to a person who is a member of the tribe and as a member of the tribe, is a descendant of someone who was born in the United States, and is listed in a federal document that officially confers status to receive title to land, cash, etc."[2] We urge CMS to allow the use of tribal identification cards as primary documentary evidence of an individual's U.S. citizenship and identity.

If tribal identification cards are not accepted as evidence of citizenship and identity, many Native American Medicaid recipients and applicants may not be able to provide other means of satisfactory citizenship documentation. Some Native Americans may not have been born in hospitals, therefore, there is no official record of their birth. Not recognizing tribal identification cards as proof of U.S. citizenship will cause great hardship for the Native American population and create a barrier to their enrollment and/or maintenance of Medicaid coverage.

We ask that all tribal enrollment cards are added to 42 CFR 435.407(a) as acceptable primary documentary evidence of an individual's U.S. citizenship and identity.

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[1] There are three instances where Native American-related documents may be used: individuals in the Kickapoo tribe may use their American Indian card designated with "KIC" as secondary evidence and Seneca Indian tribal census records and BIA tribal census records of Navajo Indians may be used as fourth-level evidence.

[2] June 21, 2006 letter from American Public Human Services Association/National Association of State Medicaid Directors to Dennis Smith, CMS.

435.407(c) and (d) The requirement that third and fourth level evidence must be issued at least 5 years before an individual's application for Medicaid is arbitrary and overly burdensome.

Most of the third and fourth level evidentiary documents listed in the Interim Final Rule are acceptable documentation only if they are dated at least five year's prior to the applicant's or recipient's original application for Medicaid. 71 Fed. Reg. at 39223-39224. This requirement will undoubtedly result in hardship for many individuals, especially those who are applying for, or are long time recipients of, nursing home care and may not possess documents that meet this time restriction. Furthermore, there is no apparent explanation in the Interim Final Rule for this stringent requirement.

We urge CMS to amend 42 CFR 435.407(c) and (d) by removing the requirement that third and fourth level documentary evidence must have been created five years prior to the individual's application for Medicaid.

435.407 (c) and (d) The final rule should not further limit the types of evidence that may be used to document citizenship.

CMS has asked for comments regarding whether the documentation that can be used to prove citizenship should be limited to only Tier 1 and 2. 71 Fed. Reg. at 39219-39220. We strenuously urge CMS not to limit in any way the types of documents that can be used to document citizenship status. Most Medicaid applicants and recipients will not have passports, or the financial means to obtain one. Birth certificates may also be difficult for some to obtain, especially for individuals who may have been born at home and do not have access to a birth certificate or official record of their birth, or for individuals who lost documents in natural disasters, such as Hurricane Katrina. There are many people who will only be able to provide documents that are listed in the third and fourth tiers of the documentary hierarchy established at 435.407(a)-(d), and others who will have none of the documents that are listed in the hierarchy at all (see comments related to 435.407(k) below for more on this point).

435.407(h)(1) Copies of documents should be sufficient proof of citizenship.

The new rule requires that individuals submit original documents (or copies certified by the issuing agency) to satisfy the citizenship and identity requirements. 71 Fed. Reg. at 39225. This provision of the rule poses a significant burden for both individuals and state agencies. Over the years many states have simplified and streamlined application procedures for Medicaid, including adopting a mail-in application process and eliminating face-to-face interviews. These processes reduce Medicaid administrative costs by eliminating the timely interview process and reducing staff time required for each application and renewal. They have been shown to make Medicaid more effective by increasing participation in Medicaid among people who are eligible for it. While CMS clarifies in the preamble of the rule that the documentation requirement does not prohibit utilization of mail-in application and renewal processes, the requirement that individuals submit original documents undermines those efforts. It is highly unlikely that

individuals will want to mail in their original documents and rely on the Medicaid agency to return them. Moreover, mailing original documents back to people would be quite costly for states. Furthermore, it is impractical for someone to mail in a driver's license to document their identity for Medicaid purposes because they may need to drive before they get it back. This provision of the rule will only delay coverage for new applicants forced to schedule appointments with the Medicaid agency to fulfill this requirement. Some applicants may even be discouraged from completing the application process.

The new rule also estimates that it will take recipients and applicants 10 minutes to collect and present evidence of citizenship and identity to the state, and take states 5 minutes to obtain this documentation from each individual, verify citizenship and maintain records. 71 Fed. Reg. at 39220. We believe these time estimates are extremely erroneous since the rule requires applicants and recipients to submit original documents to the state.

Nothing in the DRA itself requires Medicaid applicants or recipients to submit original or certified copies to the Medicaid agency in order to fulfill this new documentation requirement.

We urge CMS to reconsider and to eliminate the requirement in 42 CFR 435.407(h)(1) that original documents or certified copies be submitted.

435.407(h)(5) Meeting the citizenship documentation requirement in one state should suffice for any other state.

The Interim Final Rule states that documentation of citizenship and identity should be a one-time event. 71 Fed. Reg. at 39225. The Rule includes no provision for ensuring that individuals who meet the documentation requirement in one state and get onto Medicaid, then move to a different state can enroll Medicaid in their new state without providing documentation a second time. The Interim Final Rule should be clarified and amended at 42 CFR 435.407(h)(5) so that individuals truly only have to provide documentary evidence of citizenship once as the regulations intend.

435.407(j) Medicaid coverage should not be delayed because of lack of citizenship documentation.

While we commend CMS for requiring states to provide people applying for or renewing Medicaid coverage a "reasonable opportunity" to submit citizenship documentation, we are concerned that the rule is more stringent than required by Section 6036 of the DRA by not allowing people who are applying for and who are eligible for Medicaid to be enrolled until they have submitted satisfactory evidence of their citizenship status. This interpretation of the statute will cause significant delays in health care coverage and access to health care services for many very vulnerable people.

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." Although no time period is directly specified, the rule

states that the "reasonable opportunity" should be consistent with the timeframes allowed to submit documentation to establish other eligibility requirements for which documentation is needed. 71 Fed. Reg. at 39225. 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.

There is no statutory requirement to prohibit people who are otherwise eligible for Medicaid from enrolling in the program immediately. As written in Section 6036 of the DRA, the citizenship documentation requirement is a requirement for states to receive federal matching funds, not an eligibility requirement for individuals. Once someone has declared under penalty of perjury that s/he is an American citizen and met all eligibility requirements for Medicaid, s/he should be enrolled in Medicaid pending submission of the appropriate documentation of citizenship. Without this change, coverage for working families, children, pregnant women, and parents will be delayed. And without this coverage, individuals with health care needs will delay seeking care and may ultimately require more expensive care if their condition worsens. We urge CMS to revise 42 CFR 435.407(j) so that applicants who declare they are U.S. citizens and meet all the Medicaid eligibility criteria are enrolled in Medicaid, while they have a "reasonable opportunity period" to obtain the documentation necessary to prove their U.S. citizenship and identity.

435.407(k) The final rule should include a safety net for those who cannot prove citizenship.

Despite the various avenues for obtaining citizenship and identity documentation outlined in the rule, there will still be Medicaid applicants and recipients who are U.S. citizens but who are unable to come up with the kinds of documentation CMS has determined are appropriate. These individuals may be homeless, victims of natural disasters, such as hurricanes, or individuals who are incapacitated or have severe mental health issues. Although the rule commands states to assist "special populations," 71 Fed. Reg. at 39225, such as those listed above, with finding documentation of their citizenship, the rule appears to indicate that if none of the documents listed in the hierarchy are found, states may deny or terminate Medicaid, even if the individual is otherwise eligible. 71 Fed. Reg. at 39225. While some have suggested that the ability to use two written affidavits to document citizenship provides a "safety net" for those who do not have the other accepted documents, the rules for using the affidavits will make it unlikely that individuals who cannot provide any other documents to prove citizenship status will be able to offer two acceptable affidavits.

First, the preamble to the Interim Final Rule allows an individual to prove citizenship through the use of two written affidavits only "in rare circumstances." 71 Fed. Reg. at 39224. Second, the rules for using the affidavit exception are strict: individuals must obtain written affidavits by *two* individuals who have knowledge of that person's citizenship, and at least one of these individuals cannot be related to the applicant or enrollee. Additionally, the individuals making the affidavits must be able to provide proof of *their own* citizenship and identity, and the applicant or enrollee must also make an affidavit explaining why documentary evidence does not exist or cannot be obtained. 71 Fed. Reg. at 39224. An individual who cannot meet the documentation requirement will be unlikely to produce two individuals who have personal

knowledge of the circumstances of their birth or naturalization, especially if one must not be a family member. Moreover, if the individual resides in a mixed status family, those family members who can offer an affidavit may not be citizens themselves. Undoubtedly, there will be individuals who cannot obtain documents from any of the tiers, not for lack of trying, and cannot meet the affidavit requirements. As a result, U.S. citizens who are otherwise eligible for Medicaid will be denied or lose coverage.

As an alternative to the affidavit system described in the Interim Final Rule, CMS could look to the SSI program, which does have a true "safety net." If an SSI applicant who has declared U.S. citizenship cannot produce one of the required documents that indicate U.S. citizenship, they may explain why they cannot provide any of those documents, and instead, may provide any information they do have that might indicate they are a U.S. citizen. 20 CFR 416.1610. Adopting this procedure by adding a new provision to 42 CFR 435.407 would go a long way towards ensuring that citizens who cannot produce "acceptable" documentation under the new rule still be allowed to get or keep their Medicaid coverage.

We urge CMS to add a new provision at 42 CFR 435.407(k) which would adopt the SSI rules safety net.

435.1008 Foster children receiving Title IV-E assistance should be exempt from the documentation requirement.

The preamble to the Interim Final Rule states that "Title IV-E children receiving Medicaid...must have in their Medicaid file a declaration of citizenship...and documentary evidence of the citizenship...." 71 Fed. Reg. at 39216. CMS has exempted SSI and Medicare recipients from the new requirement since they already document their citizenship during the SSI and/or Medicare application processes. 71 Fed. Reg. at 39225. But Title IV-E children who receive Medicaid *do* have to document their citizenship to receive IV-E services (incorrectly stated in the preamble at 71 Fed. Reg. 29316). And as such, they should not have to document citizenship again in order to gain Medicaid coverage.

Foster children may have urgent medical and behavior health needs that necessitate a quick placement onto Medicaid. Documenting citizenship a second time for these children will lead to a delay in Medicaid coverage, which may result in a deterioration in their health or a need for more healthcare services later on.

Since foster children already must document citizenship to receive Title IV-E assistance, much like SSI or Medicare recipients document their citizenship in those programs, they should also be exempt from the Medicaid citizenship documentation requirement. We urge CMS to add an exemption at 42 CFR 435.1008 for foster children receiving Title IV-E assistance.

435.1008 CMS should use its authority to exempt additional groups of people from the citizenship documentation requirement.

The Interim Final Rule exempts Medicare and SSI recipients from the documentation requirement. 71 Fed. Reg. at 39225. Section 6036 of the DRA authorizes the Secretary of HHS to exempt other groups who have submitted proof of U.S. citizenship or nationality from the requirement.There are a number of other categories of Medicaid applicants and recipients who should be exempt from the documentation requirement because they already establish proof of their U.S. citizenship through the application process for other government benefit programs. These groups include:

- SSDI recipients in the two year waiting period for Medicare, who have met all the eligibility criteria for Medicare—including providing proof of citizenship—and are just waiting to fulfill the two year time period.
- Former SSI and Medicare beneficiaries, who for whatever reason are no longer eligible for those programs, but have established proof of citizenship in the past, and are now eligible for Medicaid.
- Former and current TANF recipients who receive Medicaid on the basis of receipt of TANF. These individuals have proven their citizenship through the TANF program.

We urge CMS to amend 42 CFR 435.1008 and exempt the categories of individuals mentioned above.

Conclusion

We thank CMS for making strides to ameliorate the harm of the new Medicaid citizenship documentation requirement, but we believe that unless the steps described above are not taken, the citizenship documentation requirement will result in Medicaid recipients and new applicants losing or being denied coverage for critical health care benefits.

Thank you for considering these comments. We would be happy to discuss them with you at any time. If you have any questions, please contact Rachel Klein, Deputy Director of Health Policy at Families USA at (202) 628-3030.

Sincerely,

American College of Nurse-Midwives
American Nurses Association
American Public Health Association
Asian and Pacific Islander American Health Forum
Association of University Centers on Disabilities
The Epilepsy Foundation
Families USA
National Alliance of State and Territorial AIDS Directors
National Association of State Long-Term Care Ombudsman Programs
National Center for Law and Economic Justice
National Hispanic Medical Association
National Immigration Law Center
National Latino Council on Alcohol and Tobacco Prevention (LCAT)

National Migrant and Seasonal Head Start Association
The National WIC Association
Out of Many, One
Project Inform
RESULTS
Summit Health Institute for Research and Education, Inc.
US Action

cc: Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs, Regulations Development Group
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Office of Information and Regulatory Affairs,
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AMERICAN COLLEGE
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With women, for a lifetime®

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. 29214 (July 12, 2006)

On behalf of the American College of Nurse-Midwives (ACNM) and its members, I submit the following comments to the rule addressing Medicaid Citizenship Documentation. ACNM represents some 7,000 certified nurse-midwives and certified midwives in the United States.

We commend CMS for ameliorating the impact of the new documentation requirement by:

1) Exempting individuals on SSI or Medicare from the new rule.
2) Clarifying that the new citizenship documentation requirement does not apply to "presumptive eligibility" for pregnant women and children in Medicaid, and that states may continue to use this effective and important strategy for enrollment.

These important steps will alleviate the burden of the documentation requirement for millions of vulnerable citizens. However, many aspects of the rule remain of concern. For the purpose of these comments we want to focus on a few particular concerns.

First, ACNM is concerned by a statement in the Preamble of the interim rule that calls into question whether a child born in the United States to a woman who is an undocumented or illegal alien (non-qualified aliens) may have access to necessary health care services under this rule. ACNM would strongly suggest that the standard of "presumptive eligibility" be provided to all children born within the borders of the United States, which would provide them with a guarantee of access to vital Medicaid health care services for their first year of life, just as is done with all children born to "categorically needy" women.

This policy would better ensure the health and well being of the child in the critical first year of its life, while a determination can be made as to the status of the mother and the eligibility of the child for additional Medicaid benefits. Such a policy puts the children first while also establishing a finite time frame for determining future eligibility.

Second, ACNM is pleased that CMS has identified one form of evidence of citizenship to be a signed statement from either a physician or midwife that was present at the time of the birth under 435.407(d)(2) of the interim rule relating to the fourth level of evidence for citizenship.

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ACNM has great concern, though, that CMS has limited the use of this verification by a physician or midwife to births that occurred five (5) years prior to application for Medicaid. ACNM fails to see any reasonable justification for such a waiting period.
In some circumstances, the health professional that attended the birth may be the only witness to the fact that a child was born in the United States and thus eligible to its protections as a citizen. ACNM respectfully asks for CMS to remove the five (5) year requirement from this section of the regulation.

Thank you for your consideration of these brief comments.

Sincerely,

Katherine Camacho Carr

Katherine Camacho Carr, CNM, PhD, FACNM
President

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THE NAVAJO NATION
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PRESIDENT
JOE SHIRLEY, JR
VICE PRESIDENT
FRANK J. DAYISH, JR.

August 11, 2006

Centers for Medicare and Medicaid Services
Department of Health and Human Services
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Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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

To Whom It May Concern:

The Navajo Nation welcomes the opportunity to provide comments to the interim final rules, 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.

The interim final rules provide that the Bureau of Indian Affairs ("BIA") Tribal Census Records of the Navajo ("Navajo Nation Census Records") shall be recognized as Tier Four (4) documentation to show proof of citizenship that must be accompanied with a second documentation from Tier Five (5) to prove identity. Under Tier Five, Native American Tribal Documents, which appears to include Certificates of Indian Bloods, can be used to prove identity. Given that Navajo Nation Census Records establish both proof of citizenship and identity, the DRA final rules should expressly indicate such determination.

Currently the Navajo Nation has approximately 85,000 Navajo Medicaid beneficiaries who receive medical care at Indian Health Service ("IHS") facilities and Public Law 93-638 healthcare facilities located throughout the Navajo Nation. Of the 85,000, about 17,600 are our Navajo elders who rely solely on Medicaid for their healthcare needs, and the majority of them do not have birth certificates. Moreover, many of our Navajo elders are former veterans, notably our honored Navajo Code Talkers, who have served their country in time of war and peace. It will be unjustifiable and unconscionable to deny our Navajo elders, along with all of our Navajo Medicaid beneficiaries, services because they simply lack the resources to comply with the new documentation requirements.

Because the Navajo Nation lies within Arizona, New Mexico and Utah, the Navajo Nation must establish partnerships and collaborations with each of the three states to ensure that all of our Navajo Medicaid beneficiaries are provided adequate service and education regarding the new documentation requirements. Since the issuance of the new documentation requirements, the Navajo Nation has not only faced inconsistencies on the interpretation of the new requirements among the states, but has also observed adverse affects on current and potential Navajo Medicaid beneficiaries. For example, many of our Navajo elders do not have birth certificates because they were born at home. Many of these elders are currently enrolled or would be eligible for Medicaid. However, with the new documentation requirements, our elders would be faced with a significant barrier in order to receive Medicaid services by them having to prove their U.S. citizenship by documents they have never possessed.

Also, of the three States, New Mexico has interpreted the new documentation requirements to mean that the Navajo Nation Census Records can be used to show proof of both citizenship and identity. However, the other states have not determined whether they will agree with New Mexico's interpretation (given that the interim rules are not clear on this issue); thus it is important the new documentation requirements be clarified on this matter in order to eliminate any inconsistent treatment of our Navajo people.

The Navajo Nation, therefore, strongly urges that the new documentation requirements be amended to clearly recognize the use of Navajo Nation Census Records to prove both citizenship and identity.

INTRODUCTION

The interim final rules recognize that Navajo Nation Census Records are a Tier Four level proof of citizenship. The pertinent provisions of interim final rules states:

> (d) Fourth level evidence of citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained with the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity must be presented as described in paragraph (e) of this section [. . .]
> (2) One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Medicaid. This document must be one of the following and show a U.S. place of birth:
> (i) Seneca Indian tribal census record.
> (ii) Bureau of Indian Affairs tribal census records of the Navajo Indians [. . .].

Taken alone, the Navajo Census Records should be sufficient to provide proof of citizenship and identity because such records are accompanied by valid and reliable citizenship and identity documents.

When the Centers for Medicare and Medicaid Services ("CMS") set out to implement Section 6036 of the DRA, that required proof of citizenship for Medicaid eligibility, they established a hierarchy of reliable citizenship documents each with a different standard of reliability:

1. Tier One is "primary evidence of citizenship and identity is documentary evidence of the highest reliability."
2. Tier Two is "satisfactory reliability."
3. Tier Three is considered "satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available."
4. Tier Four evidence of citizenship is "documentary evidence of the **lowest reliability** [. . .] and should **only** be used in the **rarest of circumstances**."

Contrary to this hierarchy, the Navajo Census Records are clearly not of the "lowest reliability" that "should [not] be only used in the rarest of circumstances." Given the history of how these records were established and the formal census process employed by the Navajo Nation, the Navajo Census Records are highly reliable and should be held as documentation use to prove both citizenship and identity.

NAVAJO NATION CENSUS RECORDS SHOULD BE RECOGNIZED AS LEGITIMATE PROOF OF U.S. CITIZENSHIP AND IDENTITY

Pursuant to the 1924 federal law granting U.S. citizenship to American Indians and Alaska Natives ("AI/AN"), in 1928, the BIA implemented a formal census process for the Navajo Nation and created the Navajo Nation Census Records of all enrolled Navajos at the time. The BIA based its enrollment on a person's blood-quantum. In order for a person to be enrolled as a member of the Navajo Nation he or she must have had at least one-fourth Navajo blood. The Navajo Nation has since maintained this enrollment requirement.

The BIA continued to control the Navajo Nation Census Records until 1982. In 1982, the Navajo Nation, pursuant to Public Law 93-638, Indian Self-Determination and Education Assistance Act as amended, assumed the BIA's responsibility for the census process and the Navajo Nation Census Records. However, the BIA monitors the Navajo Nation's process on an annual basis. From 1982 to the present, the Navajo Nation has continued to follow the BIA's census process and maintain the Navajo Nation Census Records.

The Navajo Nation employs a highly reliable and rigorous census process, as adopted from the BIA, as well as enrollment requirements, codified in the Navajo Nation Code Annotated at 1 N.N.C. § 701 *et seq.* and 1 N.N.C. § 751 *et seq.* Generally, to be an enrolled member with the Navajo Nation, a person must not only have one-fourth Navajo blood, but the person must also present an original birth certificate and documentation verifying identity (i.e. driver's license, social security card). If the Navajo Nation deems such documentation and other information requested sufficient, the Navajo Nation will issue the person a Navajo Certificate of Indian Blood ("NCIB"). The NCIB is the official document used to show proof of enrollment into the Navajo Nation.

Pursuant to Navajo Nation laws, the Navajo Nation may utilize the Navajo Nation Census Records to determine if the person is related to a person on the Census Records to establish that the person is at least one-fourth Navajo blood.[1] This generally applies to our Navajo elders requesting their NCIBs or seeking enrollment with the Navajo Nation. In most cases, our Navajo elders do not have birth certificates, because they were born at home. However, the Navajo Nation will require other forms which may indicate that the elder was born in the U.S., such as, but not limited to, hospital affidavits, baptismal certificates, family trees, marriage certificates, and/or affidavits from relatives, community members and/or leaders.

Because the BIA, an arm of the federal government, created the Navajo Nation Census Records, in which the Navajo Nation relies on for its enrollment, it is quite disingenuous that Navajo Nation Census Records are considered the "lowest of reliability" and can only be used to show proof of identity. The Navajo Nation's codified enrollment requirements and census process are of the highest reliability that should be given great deference and recognized as such in the final DRA rules.

The Navajo Nation, therefore, strongly asserts that the Secretary of the Department of Health and Human Services should exercise rationally based discretion and adopt final rules that clearly recognize the Navajo Nation Census Records serve the dual purpose of proving citizenship and identity.

OTHER TRIBAL ENROLLMENT DOCUMENTATION SHOULD ALSO BE GIVEN DEFERENCE TO BE RECONGIZED AS LEGITIMATE PROOF OF U.S. CITIZENSHIP AND IDENTITY

The Navajo Nation strongly supports the position of the CMS Tribal Technical Advisory Group ("TTAG") and other Federally-recognized Indian tribes that Native American tribal documents and Certificates of Degree of Indian Blood ("CDIB") should be recognized as legitimate documents of proof of U.S. citizenship. Prior to the publication of the interim rules, CMS TTAG, the National Indian Health Board ("NIHB"), 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 CDIB cards as legitimate documents of proof of citizenship in issuing these regulations, but again tribal comments were ignored. While Native American tribal documents and CDIB cards are

[1] The pertinent Navajo Nation law, 1 N.N.C. § 701, states:

The membership of the Navajo Nation shall consist of the following persons:

A. All persons of Navajo blood whose names appear on the official roll of the Navajo Nation maintained by the Bureau of Indian Affairs.
B. Any person who is at least one-fourth degree of Navajo blood, but who has not previously been enrolled as a member of the Navajo Nation, is eligible for membership and enrollment.
C. Children born to any enrolled member of the Navajo Nation shall automatically become members of the Navajo Nation and shall be enrolled, provided they are at least one-fourth Navajo blood.

recognized as legitimate documents for identification purposes, such documents should also be recognized as legitimate documents for proof of citizenship.

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 that only U.S. citizens, U.S. 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 as amended. 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.

Further, since the CMS already recognizes Native American tribal documents and CDIBs as satisfactory documentation of identity in the interim rules, there is sufficient basis for CMS to recognize Tribal enrollment cards and CDIBs as satisfactory documentation of primary evidence of both 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. Though the interim rules do not define the term "Native American tribal document," Tribal enrollment cards or CDIBs certainly fall within the scope of a "Native American tribal document."

As Sally Smith, Chair 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."

Therefore, the DRA final rules should be amended to include Tribal enrollment cards and CDIBs as documents used to show proof of citizenship. Because like our Navajo people, many American Indians and Alaskan Natives were not born in hospital and likely cannot produce a birth certificate or satisfactory documentation of place of birth to prove citizenship.

CONCLUSION

By not recognizing the Navajo Nation Census Records and other Tribal Documents including CDIBs and NCIBs as satisfactory documentation to prove U.S. citizenship and identity, the CMS is creating a tremendous barrier to all current and future Navajo and AI/AN Medicaid beneficiaries. However, to recognize such documents and to amend the interim rules to reflect the Navajo Nation's concerns will not only benefit our Navajo people but all healthcare providers located near and within the Navajo Nation. The same will be true for AI/AN Medicaid beneficiaries and Indian healthcare programs operated by IHS, tribes/tribal organizations, and urban Indian organizations, as well as public and private hospitals.

As we, the Navajo Nation, respect the government-to-government relationship with the U.S. so should the U.S. respect the Navajo Nation's census process in determining its citizenship and membership, who are also U.S. citizens and residence of their respective states. On the contrary, the interim rules do not implicate this relationship to the highest degree, especially because these rules adversely affect our Navajo veterans who receive Medicaid benefits. The Navajo Nation is enriched with many proud distinguished service people who bravely sacrificed their lives, at the altar of freedom, in defense of the U.S. Even before the DRA, many service people did not have birth certificates. It is, thus, an affront to our honored Navajo Code Talkers that proudly served in World War II, and military service people, like myself, who are attributed with having great significance in turning the tide of the war, to endure this type of short cited rulemaking.

Ahé'héé (Thank you) for your time and deepest consideration of the Navajo Nation's comments on the DRA interim rules.

Respectfully,

Frank Dayish, Jr.
Vice President of the Navajo Nation

cc: Michael O. Leavitt, Secretary of HHS
Mark B. McClellan, M.D., Ph.D., Administrator, CMS
Charles W. Grim, D.D.S., M.H.S.A., Director, IHS
Joe Shirley Jr., President of the Navajo Nation
Herbert Yazzie, Chief Justice of the Navajo Nation
Lawrence Morgan, Speaker of the Navajo Nation Council
Valerie Davidson, Chair, CMS Tribal Technical Advisory Group
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July 28, 2006

Centers for Medicare & Medicaid Services
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RE: Medicaid Citizenship Documentation
Interim Final Rule, 71 Fed. Reg. 39214 (July 12, 2006)

Public Children Services Association of Ohio (PCSAO) is a statewide membership organization representing the 88 county public child protection agencies in Ohio, charged with child safety and permanency.

The interim final rule on Medicaid Citizenship documentation is very concerning to PCSAO because of the **unnecessary new documentation required for Medicaid eligibility for foster children**. These rules will cause increased bureaucracy and paperwork to an already stressed system, with no benefit to our country's abused and neglected children. Additionally, it **will not save taxpayer funds (but will cause new costs), because this is a population that already requires significant eligibility processes for Title IV-E. These children are also deeply involved in the public child welfare system, and their health needs must be met.**

Children who are eligible for federal foster care payments should be exempt from the new citizenship documentation requirements. In accordance with Title IV-E regulations, state child welfare agencies already verify the citizenship status of foster care children, in the process of determining their eligibility for Title IV-E payments. Creating new, bureaucratic documentation requirements is duplicative and unnecessary. **The Deficit Reduction Act allows HHS to exempt certain program populations where their citizenship is already verified, and children in Title IV-E foster care should be exempted under this language.**

Delaying Medicaid coverage for these children could delay essential but non-emergency medical care until it becomes an emergency. At that time, this will increase healthcare costs as foster caregivers use emergency rooms and urgent care centers to obtain emergency care.

Even if the regulations specified that agencies can have added time to collect the new documentation requirements for foster children (thus awarding them eligible status vs. applicant status while the new requirements are collected), this will require unnecessary time and resources that should be spent on services to keep children safe, and strengthening families so they can raise their own children.

Copies of Birth Certificates should be acceptable documentation. Children are placed into foster care due to the fragile and often dysfunctional status of their family. Expecting child protection agencies to easily access an original or certified copy of a birth certificate from a family, is unrealistic for this population. Local agencies will frequently be required to seek original documentation from hospitals or other state agencies, causing unnecessary delays. Copies should be acceptable.

Requiring Proof of Identity, in addition to the Proof of Citizenship is unrealistic for foster children – the list of acceptable proofs of identify do not translate well in our work with families in crisis. First of all, many of the children we serve are very young, will not have a driver's license, military ID, many will not even have a school photo ID. Even if these items existed, children often arrive in foster care with a trash bag containing precious few personal items. School enrollment is already a challenge, and believing that we can efficiently obtain proof of identify from the education system is folly. Thinking we will have a parent sign an affidavit is also unrealistic, as bringing a child into agency custody sometimes is due to the unavailability of the parent, uncooperativeness of the parent, personal crisis of the parent, etc. It appears proof of identity may also be verified by another public system – such as food stamps, child support - even child protective services! Can the child protective service agency then, just proactively state the foster child's identify, upon our Medicaid documentation activities?

PCSAO strongly joins other local, state and national groups opposing the new Medicaid citizenship documentation requirements as they apply to foster children. Please support efficiency and effectiveness in federal regulations – exempt foster children from the new requirements.

Sincerely,
Crystal Ward Allen
Executive Director
Public Children Services Association of Ohio
PcsaoCrystal@sbcglobal.net

AUG 10 2006

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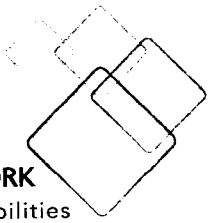

NATIONAL
DISABILITY RIGHTS
NETWORK
Protection & Advocacy for Individuals with Disabilities

August 9, 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 National Disability Rights Network is the non-profit membership organization for the federally mandated Protection and Advocacy (P&A) systems and the Client Assistance Programs (CAP). The P&A/CAP network operates in every state and territory and there also is a Native American P&A system.

NDRN strongly supports Medicaid because we believe it is a program that should make a compassionate, prosperous nation proud. This essential program has been recognized -- on a bipartisan basis -- as the driving force behind the availability of individualized, community-based supports and services that enable people with disabilities of all ages to lead fuller, healthier, and more productive lives. Individuals with disabilities, their families, and advocates fully recognize that Medicaid has its shortcomings. The most critical shortcoming in the view of NDRN and the disability community is the ongoing institutional bias that forces children and adults with disabilities to be isolated in institutions in order to obtain the long-term supports and services they need. Even with that problem, Medicaid's structure is critical to future progress toward community integration. The Medicaid entitlement; the strong federal commitment demonstrated by open-ended financing; and the extensive flexibility that states currently enjoy all help Medicaid to be innovative in addressing the needs of children and adults with disabilities.

In addition to its critical role in the lives of people with disabilities, Medicaid's impact is far broader. Medicaid is crucial to the viability of the nation's health care system. Medicaid keeps private insurance premiums lower than they otherwise would because it covers the people with the greatest needs and the highest costs; Medicaid provides critical supports to dually-eligible Medicare beneficiaries; and Medicaid financing provides essential support to the nation's public health infrastructure, including public hospitals and community health centers. According to Census Bureau figures released in August 2005, 45.8 million people — 15.7 percent of the total U.S. population — were uninsured in 2004, up slightly from 15.6 percent in the previous year. As the

number of people with private insurance falls, Medicaid provides an important counter balance. Medicaid's role in picking up the slack by enrolling low-income children as their parents lose private insurance as a result of economic changes is particularly notable.

Yet over the past several years the Administration and Congressional actions have weakened both the reach and effectiveness of the program. For example, cuts to the targeted case management and rehabilitation services option may save states dollars in the short run, but ultimately will lead to poor health, exacerbated disability, and unwarranted and costly institutional care. These policies not only fly in the face of the goals of the disability community but also are in direct opposition to the Administration's own New Freedom Initiative.

Below are NDRN comments 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 1st and requires that U.S. citizens and nationals applying for or receiving Medicaid document their citizenship and identity.

Disability Exemptions

First, NDRN is pleased that the interim rule includes the clarification that many individuals with disabilities are not covered by this rule. We commend the Centers for Medicare and Medicaid Services (CMS) for ameliorating the impact of the new documentation requirement by recognizing that indeed the intent of the statute was to exempt individuals who are dually-eligible for Medicaid and Medicare or eligible for Medicaid by virtue of receiving Supplemental Security Income (SSI). We strongly agree with the CMS statement that:

> *To adopt the literal (and in error) reading of the statute could result in Medicare and SSI eligibles, a population which are by definition either aged, blind, or disabled, and thereby most likely to have difficulty obtaining documentation, being denied the availability of an exemption which we believe the Congress intended to afford them. Accordingly, States will not be subject to denial of FFP in their Medicaid expenditures for SSI recipients who receive Medicaid by virtue of receipt of SSI and Medicare eligibles based upon failure to document citizenship.*

NDRN also is pleased that CMS acknowledges that there must be a different accommodation made for SSI recipients in certain states that do not automatically provide Medicaid to individuals who are SSI eligible. NDRN supports the CMS decision to allow the use of the Social Security Administration's State Data Exchange database (SDX), which contains the information needed to identify whether an individual already has been found to be a citizen, to be cross-matched with state vital-records and establish citizenship and Medicaid eligibility.

NDRN urges CMS to provide specific information on these exemptions to the states and to all the disability-related entities in state government to ensure the proper implementation of the law. In addition, NDRN recommends that this same information be provided directly to disability consumer, advocacy, and provider organizations. In recent years, CMS has made clear efforts to reach out to NDRN and the P&As, as well as other disability groups so that we can educate our members and

clients - as well as hold the states accountable for the proper implementation of the law. We urge CMS to continue this partnership strategy.

Children and Adults with Disabilities Who Would not be Exempted

As stated above, NDRN is pleased that CMS recognized the need for an exemption for individuals on Medicare and SSI, However, NDRN is concerned that there are some children and adults with disabilities who will not be covered by this exemption and, therefore, will not have access to the critical health services and supports they need.

For example, there are some individuals who have met the SSDI definition of disability; are in their two-year waiting period for Medicare; are in the SSA database; but not on SSI. Some of these individuals are eligible -- based on their state's requirements for Medicaid -- through a medically-needy program or for a Medicaid buy-in program. In addition, there are many minor children (under the age of 18) who receive Medicaid because they are eligible for Social Security benefits as a "survivor"

NDRN recommends that any individuals already found eligible for either SSDI or Social Security survivor benefits by the SSA (and who already have presented evidence of their citizenship or qualified immigration status to the SSA) should be exempted from these documentation requirements. Keeping these individuals from accessing the services or supports they need or taking away current service and supports is short-sighted and poor policy.

U.S. Citizen Applicants Should not Face a Delay in Benefits

NDRN is very concerned that CMS has prohibited states from granting coverage to eligible citizens until they can obtain documents such as birth certificates. 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). We urge CMS to make the DRA consistent with the Medicaid Act and accept that once an applicant for Medicaid declares he/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.

Special Populations Needing Assistance

The NDRN supports the inclusion of the section of the rule entitled "special populations needing assistance". NDRN agrees that states have the responsibility to assist their citizens who because of a cognitive, mental, physical, or sensory disability would be unable to present documentary evidence in a timely manner. NDRN believes that the term "incapacity of mind or body" is confusing and should be replaced with a more specific definition of who is being targeted here.

Children in Foster Care Must Be Exempted

The NDRN strongly recommends that children who are eligible for federal foster care payments be exempt from the citizenship documentation requirements. At least one-third of the half million children in foster care have some type of disability. According to *Forgotten Children: A Case for Action for Children and Youth with Disabilities in Foster Care*,[1] whether they experience maltreatment that results in disabilities, or are victims of maltreatment *because* of their disabilities, children who enter foster care with special needs, on average, already have experienced more than 14 different environmental, social, biological and psychological risk factors before coming into care:

- 40% are born at a low birth weight or premature;
- 80% are prenatally exposed to substances;
- 30-80% have at least one chronic medical condition [e.g., asthma, HIV, TB];
- 30-50% have dental decay;
- 25% have three or more chronic health problems;
- 30-60% have developmental delays;
- 50-80% have mental and behavioral health problems;
- 20% are classified as fully handicapped; *(term used in report)*
- 30-40% receive special education services.

Many of these children may not meet the SSI definition of disability so the above-mentioned exemption will not protect them. However, children with and without disabilities in the foster care system could be harmed by the implementation of this rule – and for no good reason.

State child welfare agencies must verify the citizenship status of these children in the process of determining their eligibility for Title IV-E payments. In addition, we understand 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 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.

The potential for harm for these children, who have been through so much already, is immense if their access to health care is delayed. They could lose needed prescription drugs and other medical equipment, dental care, mental health services, and all the other services afforded to them through the Early and Periodic, Screening, Diagnosis, and Treatment Program (EPSDT). In addition, loss of access to preventive services is simply bad public health policy and not cost effective.

NDRN believes that the DRA does not compel these documentation requirements for children in foster care. These requirements only lead to the unnecessary duplication of state efforts and put these children at risk of delayed Medicaid coverage. The DRA allows the Secretary to exempt individuals who are eligible for other programs that required documentation of citizenship. The IV-

[1] United Cerebral Palsy and Children's Rights, *Forgotten Children: A Case for Action for Children and Youth with Disabilities in Foster Care (2006)*

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.

NDRN urges 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. In addition, NDRN urges CMS to add to the list of exempted groups all populations already receiving supports and services through federal programs that have existing citizenship determination processes.

Pregnant Women and Children

NDRN applauds CMS for clarifying that the new citizenship documentation requirements do not apply to "presumptive eligibility" for pregnant women and children in Medicaid and that states may continue to use this effective and important strategy for enrollment. However, we are concerned about the eligibility of children born in U.S. hospitals. Therefore, we recommend that 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.

NDRN believes it is somewhat incongruous that 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. Under current law, infants born to U.S. citizens receiving Medicaid at the time of birth are deemed eligible for Medicaid upon birth and 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. NDRN believes this is a nonsensical requirement <u>if</u> a state Medicaid agency paid for the child's birth in a U.S. hospital and the child is then, 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.

The prevention of future disability is one of the goals of numerous federal agencies - ACF, HRSA, CDC, etc. Any rule that would delay the access of a newborn to needed health care - places that child at a higher risk for health problems or disabilities. The risk to the health and well being of newborns from delays in coverage and the potential for increased uncompensated care for providers are unnecessary.

Again, NDRN strongly urges 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.

U.S. Citizens who Lack Citizenship Documentation

There are U.S. citizens who will not be able to provide any of the documents listed in the interim final rule. 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. NDRN is concerned that under this rule some individuals who apply for Medicaid will never qualify and some individuals who are current beneficiaries will eventually lose their coverage. Again, this is poor health policy.

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

It is important to note that SSI regulations 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) NDRN recommends that the Secretary 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. This approach would ensure that children and adults who are U.S. citizens and new applicants for Medicaid can get access to the services and supports they need and those who are current Medicaid recipients will maintain their coverage.

Native Americans

The interim final rule at 42 C.F.R. 437.407(e)(6) recognizes Native American tribal documents as proof of identity, however, the regulations do not permit tribal enrollment cards to be used as evidence of citizenship. NDRN urges CMS to recognize the extremely high health care needs of many Native American children and adults. NDRN urges 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 Conclusion

The Administration's New Freedom Initiative recognizes the vital role of adequate health care and long term supports and services in the community. In the majority of cases, the only source of this health care is the Medicaid program. NDRN believes that the Documentation Requirements included in the DRA not only are an example of a needless barrier to community integration but also

an example of lawmaking by anecdote. NDRN notes that these documentation requirements have been deemed unacceptable not only by beneficiaries and health care advocates, but also providers and states. We urge CMS to seriously consider the needs of children and adults who rely on Medicaid as final regulations are drafted. We also urge CMS to consider the damage that could be done to our nation as a whole if people are denied access to the health and long term services and supports they need. If you have questions about these comments, please contact Dr. Kathleen McGinley)202-408-9514 or Kathy.McGinley@ndrn.org).

Sincerely,

Curtis Decker
Executive Director

Kathleen McGinley
Deputy Executive Director for Public Policy

CALIFORNIA HOSPITAL ASSOCIATION
Providing Leadership in Health Policy and Advocacy

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August 11, 2006

Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services
Attention: CMS – 2257 – IFC
P.O. Box 8017
Baltimore, MD 21244-8017

RE: Medicaid Program; Citizenship Documentation Requirements (CMS – 2257 – IFC)

Dear Dr. McClellan:

The California Hospital Association (CHA), on behalf of our nearly 500 member hospitals and health systems, is pleased to offer comments to the Centers for Medicare & Medicaid Services (CMS) on the interim final regulation implementing Section 6036 of the Deficit Reduction Act of 2005 (DRA) regarding new citizenship verification requirements. CHA appreciates CMS' efforts to ease citizenship documentation requirements for some Medicaid beneficiaries.

While CMS' efforts are commendable, CHA is disappointed that CMS did little to mitigate the likelihood that U.S. citizens eligible for Medi-Cal will face delay, denial and lack of coverage. Due to the burdensome and, in some instances impossible, requirements imposed on the state of California, Medi-Cal beneficiaries and their providers, CHA urges CMS to partner with affected states and their stakeholders to work aggressively to minimize the impact of this provision.

Exemptions
CHA is pleased that CMS changed the rule to exempt seniors and people with disabilities currently receiving Medicare or Supplemental Security Income (SSI) benefits, in recognition of the diversity of beneficiaries served by Medicaid. CHA urges CMS to consider expanding this exemption to include the non-elderly disabled who have severe mental and physical disabilities, the homeless, and anyone receiving Medicaid for five or more years.

Children
Title IV-E children receiving Medicaid, while not required to declare citizenship for IV-E, must have in their Medicaid file a declaration of citizenship or satisfactory immigration status and documentary evidence of the citizenship or satisfactory immigration status claimed on the declaration. CHA encourages CMS to consider an exemption for Title IV-E children on foster care and to children born on Medi-Cal.

Among the children subject to the documentation requirements are infants born in U.S. hospitals. We urge CMS to clarify that existing retroactive eligibility is not impacted by the new regulations. Retroactive eligibility allows Medicaid applicants to get coverage retroactively to three months prior to application. Maintaining retroactive eligibility will ensure children receive needed services.

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 five-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.

CHA recommends 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.

Costs

CHA is concerned that CMS does not fully comprehend that the citizenship requirements are going to translate into increased costs borne by the state, providers and beneficiaries. With respect to services furnished to otherwise eligible beneficiaries, hospitals may in many instances have to forego compensation until and unless the documentation requirements are satisfied. The new requirements will likely result in a potential increase in uncompensated care, thus having the added effect of compromising the heath status of a significant number of individuals.

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. This requirement serves only to add to the information collection burden of the regulations. 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. To satisfy this requirement, CHA recommends that states be allowed to accept and use copies of the required documents.

CMS should also take this opportunity to reassess its unrealistic burden estimate that it will only take applicants and beneficiaries ten minutes and state agencies five minutes to comply.

Compliance

CMS has stated that it will monitor the extent to which states use primary evidence to establish both citizenship and identity, and will require corrective action to ensure the most reliable evidence is routinely being obtained. CHA is concerned that the emphasis placed on the use of documentation from the primary evidence category may cause states to be overly cautious in their interpretation of the federal guidance resulting in instances where eligible individuals are denied enrollment. CHA believes that CMS should make every effort to ensure that states clearly understand that agency oversight is not intended to prevent those entitled to Medicaid benefits to be prevented from receiving them.

Thank you for the opportunity to provide comments on the proposed rule. If you have any questions, please contact me at (202) 488-4688 or mholloway@calhospital.org.

Sincerely,

Margot Holloway
Vice President, Federal Regulatory Affairs