

June 23, 2006

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Dear Dr. McClellan:

Thank you for meeting with the Tribal Technical Advisory Group (TTAG) on June 8. At that time you said that we should read the forthcoming letter to State Medicaid Directors providing guidance for documentation of citizenship and identity under the Deficit Reduction Act (DRA) and then let you know if there are any problems.

We have reviewed the letter issued on June 9 to Medicaid Directors and the accompanying CMS Fact Sheet and we are very concerned that the guidance regarding American Indians and Alaska Natives is incomplete. We urge you to address the concerns outlined below prior to issuing regulations on this important subject.

While there are more than 560 federally-recognized tribes in the United States, only three are referenced in the State Medicaid Director letter of June 10: Kickapoo, Navaho and Seneca. We assume that the reference to Navaho Indians refers to the federally-recognized Navajo Nation and the reference to Seneca Indians refers to the federally-recognized Seneca Nation. It is unclear why these three tribes were singled out to be mentioned in this guidance at the exclusion of other tribes. These three tribes are located in five states (Texas, New York, Arizona, New Mexico and Utah), but there is virtually no guidance for the other 29 states with federally-recognized tribes or for additional tribes in these five states.

On May 12 and May 18, the TTAG sent letters to you recommending that tribal enrollment cards and Certificates of Degree of Indian Blood (CDIB) cards be used as proof of citizenship. We left our discussions with you on June 8 under the assumption that this had been incorporated as guidance to State Medicaid Directors. However, these documents are only listed in the June 9 letter in chart 5 as acceptable documents for evidence of identity. This is not appropriate or workable.

Background Information about Tribal Enrollment Cards and Certificates of Degree of Indian Blood (CDIB)

The letter to State Medicaid Directors and the related Fact Sheet show an absence of research and knowledge about tribal enrollment cards and Certificates of Degree of Indian Blood (CDIB). We encourage you to consult with the Bureau of Indian Affairs and the Indian Health Service to learn more about the rules, regulations and processes that govern the issuance of these important documents.

The stringent processes for issuing tribal enrollment cards and CDIB cards have several characteristics that make the cards highly reliable documentation of citizenship. To illustrate our points we have attached copies of tribal ordinances and application forms from a sample of tribes across the country, including the following:

- The Confederated Tribes of the Grand Ronde Community of Oregon
- The Minnesota Chippewa Tribe
- The Cherokee Nation
- The Chickasaw Nation

These documents illustrate some important points that are related to documentation of citizenship.

- a. Many tribes require that the individual demonstrate a linkage by birth to a person listed in a census conducted by the federal government for the purpose of a treaty, or other federal legislation, or implementing a federal policy of land grants, or payment of land claims settlements.

Example: The Confederated Tribes of the Grand Ronde Community of Oregon links tribal membership to people listed on the official tribal membership roll prepared under the Grand Ronde Restoration Act and published in the Federal Register on June 22, 1984.

Example: The Cherokee Nation and The Chickasaw Nation require that members provide documents that connect them to an enrolled lineal ancestor who is listed on the Dawes Roll, the Final Rolls of Citizens and Freedmen of the Five Civilized Tribes, taken by the federal government between 1899-1906.

- b. Tribes have enrollment staff that review documentation to assure that there is compliance with written procedures. Tribes are very careful and conservative because they have limited resources and want to limit their programs to serving only those individuals who meet the strict enrollment guidelines. Furthermore, they do not want people voting in their elections who are not entitled to participate in their governance process.

- c. Most tribes have Enrollment Committees that review all the enrollment staff recommendations about membership applications. These enrollment committees provide a check on any kind of fraud or abuse. Enrollment committees can require additional documentation from applicants.

- d. Tribes also have procedures that involve documentation that is equal to or exceeds the guidance provided to State Medicaid Directors. The primary document required for tribal enrollment is usually a CDIB card. Issuance of tribal enrollment cards and CDIB cards relies primarily on birth certificates. However, tribes recognize that there are often home births without birth certificates and they accept other types of documentation. Tribal codes may have specific procedures to evaluate the quality of documentation.

Example: The Minnesota Chippewa Tribe requires the applicant's certified birth certificate or baptismal certificate. Complimentary copies of hospital records are not acceptable. It also accepts DNA or genetic marker testing.

Example: Wording in the tribal code for the Confederated Tribes of the Grand Ronde Community of Oregon states: “Any handwritten corrections or additions on documentation will be considered alternations. Altered documents will be unacceptable for enrollment purposes.”

Example: The Chickasaw Nation requires that a state-issued birth certificate “must show full parentage and must be signed by the state registrar. ALL birth certificates must display the state file number.” If a person submits a delayed birth certificate, the Chickasaw Nation requires additional back up documents.

Example: The form that the Cherokee Nation uses to issue CDIB and tribal citizenship cards requires not only a birth certificate for the applicant, but also CDIB or tribal roll numbers for parents and grandparents of the applicant.

e. Tribes that are close to the borders of the United States may require proof of United States citizenship.

Example: The Minnesota Chippewa Tribe application states, “If Applicant was born outside the United States, there must be proof of United States Citizenship.”

f. Many tribes are quite small and the community has knowledge regarding families and who is born to whom. Close social and economic ties to the tribe may be a condition of enrollment, in addition to substantiating the required genealogy. Some tribes require sponsors or affidavits from adults who are tribal members.

In summary, 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. That member of the tribe is descended from someone who was born in the United States and listed in a federal document that officially confers status to receive title to land, cash settlements, or other federal benefits. United States citizenship was granted to American Indians in 1924, and the genealogy establishes direct descendancy from U.S. citizens. Thus, the issuance of CDIB cards and tribal enrollment cards meets the requirements for citizenship that a person is 1) born in the United States, or 2) born to parents who are U.S. citizens.

The State Medicaid Director letter on page 10 under Reasonable Opportunity, states:

A determination terminating eligibility may be made only 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.

By accepting tribal enrollment cards and CDIB cards as evidence of citizenship, it will reduce the administrative burden on states, on tribes, and on the Indian Health Service to obtain other types of evidence. It will also assure that people are enrolled in Medicaid in a timely way. Delay, denial, and termination of enrollment in Medicaid for those who are eligible but noncompliant in producing required documentation will result in increased costs for uncompensated care in private and community hospitals. It will also result in reduced revenues to the Indian health facilities that will widen the gap in health disparities.

Recommendation: American Indian enrollment processes and legal history provide ample justification for the Secretary to exercise his discretion under the Deficit Reduction Act to use tribal enrollment cards and CDIB cards as documents for proof of citizenship. These should be added to Chart 2 as second level documents.

Specific Comments on the Wording in the State Medicaid Directors Letter

We are concerned that the wording in the letter to State Medicaid Directors on June 9, 2006, will be substantially replicated in the regulations that CMS issues to carry out the citizenship and identity requirement in the DRA. For that reason, we offer very specific recommendations about changing the wording.

Page 2, B. Documents Establishing U.S. Citizenship and Identity, paragraph 1

The letter says, “Charts 1-4 establish a hierarchy of lesser reliability of citizenship documents and the following instructions specify when a document of lesser reliability may be accepted by the State.”

On June 8, you told the Tribal Technical Advisory Group (TTAG) that the fourth tier doesn’t mean that the form of documentation is unacceptable, but rather that states should look at the other tiers first. However, states are concerned that if they use fourth tier documentation too often, it will generate an audit and potential disallowances of the federal match. You left the impression that AI/AN constitute such a small number of Medicaid beneficiaries that it would not create problems for states if AI/AN were treated as exceptions. However, in states where AI/AN constitute more than 10 percent of the Medicaid population, there is a concern that the use of tribal enrollment cards and/or affidavits will cross the threshold for audits.

Furthermore, if tribal enrollment cards and CDIB cards are in the fourth level of citizenship documentation (which currently references Seneca and Navaho Indians), then the tribal member must produce two forms of identification. If an adult does not have a driver’s license and has not served in the military, then it would be difficult to produce the two identity documents on the list. This requirement simply does not make sense for American Indians and Alaska Natives who generally live in small communities where they are known by everyone. Thus, the fourth tier creates an unnecessary hardship and an extra barrier to Medicaid enrollment for American Indians and Alaska Natives.

To assure states that they can consider tribal enrollment cards and CDIB cards as acceptable documentation of citizenship, these documents should be moved into the second tier. Furthermore, wording should be added in this section to clearly give states more latitude to evaluate the evidence using guidelines established by CMS. In light of the stepped up auditing of State Medicaid programs (by both CMS and the States themselves) we ask that your verbal assurance to the TTAG be formally conveyed to the State Medicaid Directors so they have written documentation of the flexibility granted to AI/AN.

Recommendation: Add a statement, “States may accept tribal enrollment cards and CDIB cards as evidence of United States citizenship in any of the tiers if they are issued by a tribe or the federal government using written procedures that assure that documentation is used that is equivalent to the documentation described in the tier to which they are ascribed.”

Page 4, Chart 2, Secondary Documents

As described in the background information on tribal enrollment cards and CDIB cards, these are equivalent to the documents listed as Secondary Documents.

Generally speaking, the federal government treats all federally-recognized tribes in the same way when it comes to policy and access to federal programs. Instead of naming three specific tribes in this letter, there should be a statement regarding tribal enrollment cards and CDIB cards that applies to all tribes.

Recommendation: Add to the left column: “Certificates of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs (BIA) or by a tribe authorized by the BIA to issue the CDIB cards.” Add to the left column, “Tribal Enrollment Cards issued by federally-recognized tribes.” The explanation section for this could include that the procedures for issuing a tribal enrollment card must include a birth certificate or equivalent documentation.

Page 6, Chart 3, Hospital Records

The requirements for “extract of hospital record on hospital letterhead” may be a challenge for Indian Health Service hospitals that use federal forms rather than letterhead. Furthermore, most American Indian and Alaska Native people would have no reason to request this documentation five years prior to applying for Medicaid. The Medicaid application would be the event that generates the request for the medical record. A form generated by an Indian Health Service or tribally-operated hospital that establishes that there is a medical record documenting the birth should be sufficient for this purpose.

Recommendation: In the explanation section, add the following statement, “Copies of documents from Indian Health Service hospitals will be accepted if they are on federal forms.”

Page 7, Chart 4, Other document as listed in the explanation that was created at least 5 years before the application for Medicaid

The explanation section makes reference to “the Seneca Indian tribal census record” and “the Bureau of Indian Affairs tribal census records of the Navaho Indians.” According to the guidance, only these records that are five years before the application for Medicaid can be considered. There are multiple problems with this guidance, including the following:

- a. It is not clear whether this is referencing records created by the U.S. Census, or lists of tribal members created by the federal government as part of legal proceedings with the tribe, or current tribal enrollment lists.
- b. The Bureau of Indian Affairs no longer keeps these records for all tribes. In many instances, tribes keep these records under agreements with the BIA.
- c. Tribal enrollment is updated continuously and it may be difficult to use records that are 5 years old or older, rather than current records.
- d. There will be no tribal enrollment records older than 5 years for children under 5 years old.

In the absence of further explanation, it can be inferred that other federally-recognized tribes that have enrollment processes substantially the same as the Navajo Nation and the Seneca Nation are entitled to have their tribal enrollment cards regarded in the same way for purposes of documentation of citizenship for Medicaid eligibility. It would be clearer to address the tribal enrollment cards in a more comprehensive way that provides guidance to all states for all tribes.

Recommendations: As already stated, tribal enrollment cards and CDIB cards should not be in tier 4. If CMS persists in keeping this in tier 4, then it should omit reference to specific tribes and use instead the following wording, “Enrollment card issued by federally recognized tribes” and in a separate bullet, “Certificates of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs (BIA) or a tribe authorized by the BIA to issue CDIBs.” Also, the 5-year requirement should be omitted.

Page 7, Chart 4, Written Affidavit

It is unclear what it means to have “personal knowledge of the events establishing the applicant’s or recipient’s claim of citizenship.” The wording should be clarified so that it is not interpreted that a person must state that they were present at the birth. Home births generally have very few witnesses and those who were present are likely to be dead if the Medicaid applicant is over 40 years old. It should be sufficient to state that there is general knowledge among relatives and within the community about the mother of a child, and that both mother and child were born in the United States.

Recommendation: Omit the word “personal” from the statement.

Page 8, Chart 5, Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.

The CDIB is more appropriate as a document of citizenship than identity, because it establishes a record of birth and genealogy. It links the person to an indigenous person who was born in the United States.

While the Certificate of Degree of Indian Blood (CDIB) is listed as a document to establish identity, a condition is attached that the document must include a photograph. Historically, the CDIBs issued by the Bureau of Indian Affairs did not have photographs. Some tribes that have taken over issuance of CDIBs have included photographs, but this practice is quite limited. To our knowledge, there is no funding for tribes to re-issue CDIB cards with photographs and this would create an undue hardship on tribes and an unnecessary barrier to tribal enrollment.

It must be assumed that most American Indian and Alaska Native Medicaid applicants will not have passports because most have never had the resources or opportunity to travel outside the country. This requirement essentially puts virtually all AI/AN in the position of having to supply both documentation of citizenship and one or two forms of identity. By adding the requirement of a photograph as part of a CDIB card, it essentially eliminates the CDIB as one form of identity. The remaining list of items that could be used for establishing identity is too limited for many people to qualify. Seven items are listed as acceptable documentation, but three of them are related to the military or Coast Guard. A pregnant young woman or an elderly woman is unlikely to be able to produce those types of documentation. If she is not in school and does not have a driver’s license, she is limited to only three types of identification: a government identification card, a tribal document, and an affidavit. If she has already used an affidavit to show citizenship,

then she cannot use it for identity. This means that she has to get a government identification card. The opportunities for doing that might be quite limited for a person living on a reservation without a driver's license, or living in an Alaska village. Thus, this becomes a significant barrier to Medicaid enrollment.

Recommendation: 1) As stated previously, tribal enrollment cards and CDIB cards should be moved into a tier of accepted documents to prove citizenship that does not require two forms of identity. 2) Eliminate the requirement for a CDIB card to have a photograph. 3) Eliminate the requirement that an affidavit cannot be used to establish identity if it is used to establish citizenship. 4) Expand the list of documents that can be used to establish identity to include such things as utility bills, bank statements, payroll stubs, rent receipts, prescriptions, etc.

Page 12, Outreach Plan

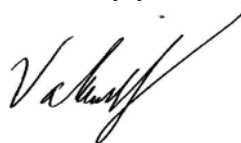
As with other efforts by CMS, the outreach plan needs to include tribes and the Indian Health Service, as well as states. Furthermore, outreach by both CMS and states must take into account the unique circumstances related to American Indian and Alaska Native populations and their health care system. Indian health employees are better able to assist in the transition if they know the schedule for redetermination and other specific information.

Summary

Historically, American Indians who are eligible for Medicaid have had lower rates of enrollment in Medicaid than other groups. We believe that Congress' intention in the DRA was not to create further barriers to enrollment for First Americans, but rather to guard against abuse by individuals who are not United States citizens.

We urge you to meet with Secretary Leavitt to discuss American Indian enrollment processes and relevant legal history that provide justification for the Secretary to exercise his discretion under the Deficit Reduction Act to use tribal enrollment cards as second level documents. Please incorporate these necessary changes in the guidance to State Medicaid Directors and in the forthcoming regulations.

Sincerely yours,



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