

# Tribal Technical Advisory Group

to the Centers for Medicare and Medicaid Services

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January 31, 2007

Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services  
200 Independence Ave  
Washington, D.C. 20201

Dear Ms. Norwalk,

On behalf of the Tribal Technical Advisory Group (TTAG), I want to thank you for attending the TTAG meeting held November 14 -15, 2006 in Washington, D.C. We appreciated the opportunity to begin our discussion on serious Medicare and Medicaid issues affecting tribal communities. We respectfully request your presence at the February 22 - 23, 2007 TTAG meeting to discuss with you further how the Medicaid citizenship documentation requirements negatively impact Indian Medicaid beneficiaries and tribes. Not only are some previously eligible American Indians and Alaska Natives (AI/ANs) unable to access Medicaid programs but Indian health programs will see a decline in revenue and increase in expense for purchased health services.

At the November TTAG meeting, I, as chair of the TTAG, expressed disappointment that tribal enrollment cards or Certificates of Degree of Indian Blood (CDIB) were not recognized as acceptable documentation of proof of U.S. citizenship for Medicaid eligibility purposes. At the TTAG meeting held in June 2006, Dr. McClellan indicated that CMS would thoughtfully consider tribal concerns submitted through the TTAG process. At that time, the TTAG requested that when CMS issued the regulations, tribal enrollment cards or CDIBs be recognized as legitimate documentation of proof of U.S. citizenship. On the TTAG conference call held on August 9, 2006, tribal leaders reviewed with CMS staff in detail the tribal enrollment process and explained how the vigorous tribal enrollment process documents proof of citizenship. Despite several meetings of the TTAG with Dr. McClellan and other CMS staff, the interim regulations published on July 12, 2006 (71 Federal Register 39214) did not recognize tribal enrollment cards or CDIBs as legitimate documents of proof of U.S. citizenship. Tribes and tribal organizations, as well as Dr. Grim, as Director of the Indian Health Service (IHS), submitted comments on the interim regulations. The comment letters explain in great detail why tribal enrollment cards or CDIBs should be recognized by CMS as sufficient documentation of proof of U.S. citizenship for Medicaid purposes. For your convenience, I have enclosed copies of the letters.

In reviewing the interim regulations, it is apparent that CMS relied heavily on the Social Security Administration's (SSA) Program Operation Manual when it drafted the citizenship documentation rule. Specifically, RM 00203.310 (Evidence of U.S. Citizenship for an SSN

Card) was used by CMS, almost verbatim. Unfortunately, the SSA program manual was inappropriately relied on as the only source document for addressing proof of U.S. citizenship for AI/ANSS. The SSA manual named only: “Seneca Indian tribal census record; Bureau of Indian Affairs tribal census records of the Navaho [sic] Indians.” Thus, only two of the over 560 tribes were identified. The CMS interim regulations do not explain the criteria for why these tribes were explicitly included or why others were excluded. The CMS staff were unable to adequately explain the criteria used by the SSA to include only these two tribes. Despite the advice of the TTAG and many tribal governments, the only change CMS made in response to tribal comments to the interim regulations was to correct the spelling of the Navajo Nation.

As you recall at the TTAG meeting, I explained that not accepting tribal enrollment cards placed an undue burden on Indian people to obtain other proofs of documentation, especially for Indians living in very remote regions where there are no roads connecting communities. For instance in Alaska, in a 75,000 square mile area there is only one state office, the Division of Motor Vehicles (DMV), where someone can get a driver’s license or state identification card. Last year this DMV office was only open for two months and travel to this office is only accessible at airfares ranging from between \$600 to \$800. I also indicated that it was my understanding that although CMS might have concerns that some tribes may issue enrollment cards to members who live across the U.S. border; for CMS to create a hurdle for 99% of a population due to concerns with 1% of that population is not a rationale policy. In addition, Frank Dayish, Jr., co-chair of the TTAG, added that on the Navajo Reservation a significant number of tribal members were not born in an IHS hospital and do not have birth certificates.

At the November TTAG meeting, you requested problematic and personal stories caused by the new citizenship requirement for Medicaid enrollment and re-determination of Indian Medicaid beneficiaries. The TTAG has been able to identify significant impacts in Indian communities that serve as strong examples of how frustrating and cumbersome the new Medicaid documentation requirements can be on the Medicaid beneficiaries and the Indian health programs that serve them. Although the Medicaid documentation requirements are impacting all Medicaid populations, Indian Medicaid beneficiaries are being impacted unnecessarily by having to produce other documents when their tribal enrollment cards or CDIBs would accomplish the same purpose.

For instance, the new citizenship requirement has had a significant impact on the Medicaid enrollment of Chemawa Indian Boarding School students in Salem, Oregon. In the past the State of Oregon has always deemed the students to be residents and eligible for Medicaid. The boarding school would certify the students’ status based on tribal enrollment documents and the state recognized the students as residents during the months residing on campus and accepted copies of the students’ birth certificates. All of these students are tribal members and have to produce proof of tribal membership prior to enrollment at the boarding school. Tribal enrollment records as well as copies of the birth certificates are already in the students’ files.

Prior to the citizenship documentation requirement, 99% of the Chemawa students were covered by Medicaid. Now, only 35% are covered by Medicaid. Copies of birth certificates were always submitted with the applications previously. Implementation of the Medicaid citizenship documentation requirements, without due recognition to tribal enrollment documents, will unnecessarily result in a decrease in Medicaid revenue for the Indian health programs serving

these students. This loss of revenue for otherwise eligible children will, in turn, result in a decrease in funding for all other AI/ANs using the Portland Area Indian health programs.

Students who attend the Chemawa Indian Boarding School represent 60 different Federally-recognized tribes from across the country. Thus, the problem that Medicaid eligible students at Chemawa are experiencing is not limited in scope but impacts Indian tribes on a national basis. Because most of the students come from and were born in States other than Oregon the process to obtain the “certified” copies of birth certificates has become a long and laborious one for IHS staff at Chemawa and for the individual student’s tribe. Each parent or guardian has to be contacted individually in an attempt to obtain an original certified copy of the birth certificate. This additional duty has added many hours to the already full duties of the IHS Business Office staff. This process will be an ongoing process as students leave the school during the school year and new students replace them.

In addition to the Chemawa Boarding school, the TTAG has heard of other instances where there is tremendous difficulty in obtaining the required documents, which mean, AI/ANs go without Medicaid services and the IHS or tribal programs are not able to be reimbursed for Medicaid services provided. Tribes have reported problems with the Medicaid office being unsure of what documentation is acceptable from AI/ANs as proof of citizenship. In some instances the tribal program is unaware that the Medicaid program is requesting additional information to maintain enrollment because the information is sent to the enrollee, who may not understand how to meet the new citizenship requirement or provide other documentation. I must emphasize that Indian health programs serve all eligible Indian patients, therefore a patient is entitled to receive health care whether or not they are enrolled in Medicaid. Getting eligible patients to enroll in Medicaid is very difficult because their only incentive is to help their tribal health programs. The citizenship documentation requirements present an additional barrier to AI/AN enrollment that can be mitigated by explicitly allowing the use of existing documentation – the tribal enrollment cards or CDIBs.

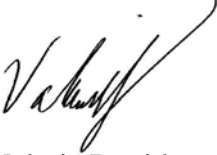
By not recognizing tribal enrollment cards as satisfactory documentation of U.S. citizenship CMS is creating an additional barrier to AI/ANs access to Medicaid benefits. AI/ANs only became legal citizens and voters of this country in 1924, four years after women won the right to vote. Today, many Indian people say that they want nothing to do with the “white man’s government”. Documentation of numerous types has been used time and again to remove land, services, and even children from Indian communities. Indeed, Indians do suffer from many social ills and face political ostracism that had its genesis in the unscrupulous tactics of agents from past governmental administrations. The result is an innate fear and mistrust of government entities.

Because of this, many Federal agencies in implementing new initiatives have experienced challenges in encouraging AI/ANs to participate in Federal programs. For instance, the U.S. Census Bureau, the Social Security Administration, the IHS, and organizations working to activate voters all have struggled against fear and mistrust when reaching out to Indian Country. However, many of these Federal agencies have worked with tribes to overcome this mistrust of governmental entities through a better understanding of tribal procedures and practices. Based on the Federal government’s unique government to government relationship with Indian tribes, the CMS has a legitimate rationale for recognizing tribal enrollment cards and CDIBs as sufficient documentation of U.S. citizenship for Medicaid purposes.

In addition to anecdotal information, you requested more information on tribal enrollment documents and the tribal enrollment process. On behalf of the TTAG, I ask you to review the 32 letters from tribes, tribal organizations, and the IHS, explaining why tribal enrollment cards and CDIBs should serve as sufficient documentation of U.S. citizenship. The TTAG invites you to attend the February 22 -23 TTAG meeting to discuss the tribal enrollment process in person with tribal leaders.

If you require additional information or have particular questions, please contact Cinda Hughes, Chair of the TTAG policy subcommittee on 202-466-7767, ext. 591.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Davidson", with a long, sweeping flourish extending to the right.

Valerie Davidson, Chair  
Tribal Technical Advisory Group

Copies of letters submitted by Tribes or Tribal organizations commenting on the Centers for Medicare & Medicaid Services Interim Final rule implementing the Medicaid citizen requirements published at 71 Federal Register 39214 (July 12, 2006):

- 1 Lummi Nation
- 2 Jamestown S'Klallam
- 3 Sonoma County
- 4 Alamo Navajo
- 5 Leech Lake
- 6 Zuni Tribe
- 7 Albuquerque Area Indian Health Board
- 8 Penobscot Nation
- 9 Menominee Tribe
- 10 California Rural Indian Health Board
- 11 Iowa Tribe of Oklahoma
- 12 Pueblo of Tesuque
- 13 Kaw Nation
- 14 Portland Area Indian Health Board
- 15 Indian Health Council
- 16 National Indian Health Board
- 17 CMS TTAG
- 18 McKinley Community Alliance
- 19 National Indian Council on Aging
- 20 Pueblo of Jemez
- 21 Cherokee Nation
- 22 United South & Eastern Tribes
- 23 Mississippi Band of Choctaw Indians
- 24 Navajo Nation
- 25 Pueblo of Isleta
- 26 Hopi Tribe
- 27 Alaska Native Tribal Health Consortium
- 28 National Congress of American Indians
- 29 Inter-Tribal Council of Arizona
- 30 Fond du Lac Reservation
- 31 Washoe Tribe of Nevada & California
- 32 Director, Indian Health Service/HHS