TAB A

BNA's Health Care Daily, Vol. 11, No. 121 (June 23, 2006)

Ohio Delays Enforcement of Citizenship Rule; Says More Time Needed to Issue Guidelines

CINCINNATI--Ohio will not enforce the July 1 deadline requiring Medicaid recipients to prove citizenship, opting instead for a delayed enforcement date of Oct. 1.

The state needs more time to prepare new guideline materials, train counselors, and advise Medicaid clients who might be at risk of losing their coverage, Ohio Department of Job and Family Services spokesman Jon Allen said June 22.

Given that federal clarification of acceptable documents did not come earlier this month, Ohio found it impossible to be ready in time, said Allen. During the three-month gap Ohio will require Medicaid applicants to attest that they are citizens, just as it does now, he said.

Under new federal guidelines, people applying for Medicaid must produce proof that they are U.S. citizens by showing a passport, birth certificate, or other documentation.

Of Ohio's 1.7 million Medicaid recipients, the state cannot estimate how many are illegal immigrants, said Allen. However, state officials do not consider false citizenship claims for Medicaid purposes to be a widespread problem, he said.

The Centers for Medicare & Medicaid Services would not say whether states that miss the deadline would face penalties. A statement released by the federal agency June 9 said states must assure compliance in order to obtain federal matching funds.

The citizenship proof requirements are part of the Deficit Reduction Act of 2005, which President Bush signed into law early in 2006.

TAB B

APPENDIX ~ D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

RECEIVED
2005 APR 12 PM 3:50
OFFICE OF INSPECTOR GENERAL

DATE: APR - 8 2005

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Self-Declaration of U.S. Citizenship for Medicaid" (OEI-02-03-00190)

Thank you for the opportunity to review and comment on the above OIG draft report. OIG reviewed the extent to which states allow self-declaration of U.S. citizenship for Medicaid and related programs and identified potential vulnerabilities associated with quality control activities and evidence used to verify citizenship.

States must provide Medicaid to all United States citizens who otherwise meet the eligibility criteria of the state's Medicaid program. Aliens' eligibility for full Medicaid coverage is limited to certain "qualified aliens." Per section 1137(d) of the Social Security Act, states must require, as a condition of eligibility, a declaration in writing, signed under penalty of perjury, that an applicant is a citizen or national of the United States. Pursuant to that statutory provision, the Centers for Medicare & Medicaid Services (CMS) permits states to accept applicants' self-declaration of citizenship, but also to require further verification, if necessary. This flexible policy allows states to enroll eligible individuals while preserving program integrity. It is in line with a larger effort promoted by CMS to help states simplify the Medicaid application process.

As there are inherent challenges in trying to provide Medicaid benefits expeditiously, while still ensuring the accuracy of eligibility determinations, OIG conducted this review. We appreciate OIG's efforts. OIG's findings reinforced our policy approach. The 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. The review also recommended steps for improving safeguards that CMS and states have already undertaken.

The OIG's draft report provided three specific recommendations for improving safeguards. Those recommendations and our responses are as follows.

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OIG Recommendation

The CMS should strengthen post-eligibility quality controls in states that allow self-declaration.

CMS Response

We concur. We agree that states should have strong post-eligibility quality control activities in place in order to reduce losses from all eligibility errors, including self-declaration of citizenship. In fact, CMS' Medicaid Eligibility Quality Control regulations require states to verify that the state properly determined the citizenship status of sampled active cases. Pursuant to Federal regulations at 42 CFR 431.812(e), states "must collect and verify all information necessary to determine the eligibility status of each individual included in an active case selected in the sample as of the review month and whether Medicaid payments were for services which the individual was eligible to receive."

The report does not find particular problems regarding false allegations of citizenship, nor are we aware of any. However, we believe that, as with self-declarations of income, states that accept self-declaration of citizenship need to have systems in place for some type of post-eligibility check to ensure that the self-declaration procedure is reliable. CMS is taking steps to have states strengthen post-eligibility controls by requiring a review of the correctness of eligibility determination under the proposed Payment Error Rate Measurement regulation, published on August 27, 2004. In the absence of any indication that there are improper self-declarations, we do not think we need to do more at this time. The CMS also will reiterate its policy at the 2005 fall meeting of the National Association of State Medicaid Directors.

OIG Recommendation

The CMS should issue a complete list of evidence that states may reference when determining eligibility.

CMS Response

We concur. For states that choose to require documentation of applicants' citizenship, CMS has provided a list of acceptable documentation in its State Medicaid Manual, which is posted on its Web site. The U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service) recently published a regulation containing a longer list of documentation that states may use. The CMS currently references that regulation on its Web site, but will adopt the OIG's recommendation and post the new list per se. In addition, at the time we publish our next State Medicaid Manual update, we will include the new list.

Page 3 – Daniel R. Levinson

OIG Recommendation

The CMS should explore allowing state Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource.

CMS Response

We concur. This recommendation reinforces our current approach, which permits states to accept citizenship verification from other programs. We articulated the principle of permitting states to accept other programs' determinations with respect to particular eligibility requirements in our Guide to Medicaid eligibility, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage." We will provide technical assistance to states that request it.

While OIG's report reinforces our current policy approach to provide states with the flexibility to enroll eligible individuals while preserving program integrity, we will follow up on OIG's recommendations as stated above.

TAB C

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SELF-DECLARATION OF U.S. CITIZENSHIP FOR MEDICAID

Daniel R. Levinson
Inspector General

July 2005
OEI-02-03-00190

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. The OEI also oversees State Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to the OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

OBJECTIVES

Our objectives were to determine the extent to which States allow self-declaration of U.S. citizenship for Medicaid and related programs and to identify potential vulnerabilities, if any, associated with quality control activities and evidence used to document citizenship.

BACKGROUND

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 restricts eligibility for Medicaid to U.S. citizens, nationals of the United States, or qualified aliens. Since 1986, verification of U.S. citizenship for purposes of Medicaid eligibility has been governed by section 1137(d) of the Social Security Act (the Act). The Act requires "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States." Pursuant to the Act, the Centers for Medicare & Medicaid Services (CMS) allows, but does not require, States to accept self-declaration of citizenship without requiring submission of additional documentary evidence. In September 2002, CMS planned to issue a final rule that would permit States to continue using self-declarations of citizenship for Medicaid eligibility.[1] At that time, OIG agreed to conduct an inspection on the extent to which States allow self-declaration. Subsequently, CMS withdrew the proposed rule. However, OIG completed the inspection because of its potential value in the administration of the program.

In recent years, CMS has encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process.[2] While the policy to allow applicants to self-declare citizenship can result in rapid enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false citizenship statements. As such, there are inherent challenges in trying to provide Medicaid benefits expeditiously while still ensuring the accuracy of eligibility determinations. In a 2001 pamphlet, CMS provided information on how to maintain program integrity while attempting to simplify the

[1] Centers for Medicare & Medicaid Services, "Medicaid Program: Self-Declaration of Citizenship," CMS-2085-P, Sept. 12, 2002.

[2] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

application process. These strategies include verifying the accuracy of citizenship statements against other nonapplicant sources, such as State vital statistics databases, and/or conducting posteligibility-focused reviews.[3]

For this inspection, we gathered information from State Medicaid directors and their staff responsible for quality control activities. Additionally, we surveyed State Temporary Assistance for Needy Families (TANF) directors, State foster care directors, and Social Security Administration (SSA) officials.

FINDINGS

Forty-seven States allow self-declaration of U.S. citizenship for Medicaid; nearly all of these require evidence if statements seem questionable. Pursuant to Federal policy, States may accept a signed declaration as proof of U.S. citizenship from applicants seeking Medicaid benefits. Currently, 40 Medicaid directors report that their State allows self-declaration of citizenship. An additional seven report that self-declaration is sometimes allowed. The four remaining directors report that self-declaration is not permitted in their State. These States are Montana, New Hampshire, New York, and Texas.

Forty-four of the forty-seven States that allow or sometimes allow self-declaration have "prudent person policies" which require evidence of citizenship if statements seem questionable to eligibility staff. Thirty-two of these have written prudent person policies, and the remaining 12 have unwritten, informal policies requiring documentation for questionable statements.

Twenty-seven States do not verify the accuracy of any U.S. citizenship statements as part of their posteligibility quality control activities. In fiscal year 2003, 27 of the 47 States that allow self-declaration did not conduct quality control activities that included verification of statements of U.S. citizenship. Of the 20 States that did review statements, 9 did so for a nonrepresentative sample of the entire Medicaid population. Consequently, some groups that could pose vulnerability to Medicaid integrity were not included in the review sample.

[3] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

Some States use types of evidence that are not accepted by CMS or SSA to document citizenship for Medicaid. As reported earlier, seven States sometimes allow and four States do not allow Medicaid applicants to self-declare citizenship. Of these 11 States, 4 use types of evidence to document citizenship that are not accepted by CMS or SSA. Furthermore, 13 of the 20 States that report conducting quality control to verify statements of U.S. citizenship use types of evidence that are not accepted by CMS or SSA, such as school records, family Bibles, voter registration records, and marriage licenses.

Medicaid-related programs are more likely to verify citizenship; their verifications may be a useful resource for Medicaid. SSA states that all applicants must provide documentary evidence of U.S. citizenship in order to receive a Social Security number or qualify for Supplemental Security Income (SSI) benefits. Forty-two of fifty-one foster care directors report that staff document U.S. citizenship when determining eligibility for Title IV-E foster care maintenance payments. Twenty-seven of fifty-one TANF directors report documenting or sometimes documenting citizenship for purposes of eligibility.

In the majority of instances, we found that these Medicaid-related programs draw on evidence accepted by CMS or SSA to document statements of U.S. citizenship. These citizenship verifications may be a useful resource for Medicaid.

RECOMMENDATIONS

We recognize that there are challenges in providing Medicaid benefits expeditiously while ensuring the accuracy of eligibility determinations. By their nature, self-declaration policies have inherent vulnerabilities in that they can allow applicants to provide false statements of citizenship. As such, it is vital to have protections in place to prevent such practices.

Based on the descriptive information we collected from States, we conclude that existing safeguards at the point of entry into Medicaid and during posteligibility quality control could allow false statements of citizenship to go undetected. Below are three recommendations for improving safeguards:

- CMS should strengthen posteligibility quality controls in States that allow self-declaration.

- CMS should issue a complete list of evidence that States may reference when determining eligibility.
- CMS should explore allowing State Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has already taken steps to improve safeguards to prevent applicants from providing false statements of citizenship. The full text of CMS's comments is included in Appendix D.

We note several issues with CMS's current efforts. Specifically, CMS explained that, pursuant to Federal regulations, States must verify statements of citizenship for sampled active cases as part of their posteligibility quality control procedures. We reiterate that this regulation applies only to States that operate traditional quality control. States that operate under a pilot or a section 1115 waiver with a quality control component are not required to verify all elements of eligibility, including statements of citizenship, as part of their posteligibility case file review.

CMS also commented that States choosing to accept self-declaration of citizenship need to have systems in place for some type of posteligiblity check to ensure that the self-declaration procedure is reliable. CMS stated that it is taking steps to do this by requiring a review of the accuracy of eligibility determinations as part of the Payment Error Rate Measurement (PERM) project. Currently, the Office of Management and Budget is working with CMS to define the scope of the PERM project. As of June, no decision has been made regarding the inclusion of errors related to Medicaid eligibility determinations.

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INTRODUCTION

OBJECTIVES

Our objectives were to determine the extent to which States allow self-declaration of U.S. citizenship for Medicaid and related programs and to identify potential vulnerabilities, if any, associated with quality control activities and evidence used to document citizenship.

BACKGROUND

Title XIX of the Social Security Act (the Act) establishes Medicaid as a jointly funded, Federal-State health insurance program. To qualify for the full range of Medicaid benefits provided under a State plan, an applicant must be either a citizen or a national of the United States or a qualified alien.[4] Since 1986, verification of U.S. citizenship for purposes of Medicaid eligibility has been governed by section 1137(d) of the Act, which requires "a declaration in writing, under penalty of perjury . . . stating whether the individual is a citizen or national of the United States."[5] Pursuant to the Act, the Centers for Medicare & Medicaid Services (CMS) allows, but does not require, States to accept self-declaration of citizenship without requiring submission of additional documentary evidence. In September 2002, CMS planned to issue a final rule that would permit States to continue using self-declarations of citizenship for Medicaid eligibility.[6] At that time, OIG agreed to conduct an inspection on the extent to which States allow self-declaration. Subsequently, CMS withdrew the proposed rule. However, OIG completed its inspection because of its potential value in the administration of the program.

In recent years, CMS has encouraged self-declaration in an effort to simplify and accelerate the Medicaid application process.[7] While the policy to allow applicants to self-declare citizenship can result in rapid

[4] The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PL 104-193).

[5] Social Security Act § 1137 (d)(1)(A).

[6] Centers for Medicare & Medicaid Services, "Medicaid Program: Self-Declaration of Citizenship," CMS-2085-P, Sept. 12, 2002.

[7] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

enrollment, it can also result in inaccurate eligibility determinations for applicants who provide false citizenship statements. As such, there are inherent challenges in trying to provide Medicaid benefits expeditiously while still ensuring the accuracy of eligibility determinations. In a 2001 pamphlet, CMS provided information on how to maintain program integrity while attempting to simplify the application process. These strategies include verifying the accuracy of citizenship statements against other nonapplicant sources, such as State vital statistics databases, and/or conducting posteligibility-focused reviews.[8]

Personal Responsibility and Work Opportunity Reconciliation Act of 1996

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) restricts eligibility for means-tested, federally funded public benefit programs to U.S. citizens or qualified aliens. This same legislation directed the Attorney General to establish verification guidance and procedures that States must follow in verifying the citizenship or immigration status of individuals applying for federally funded public benefit programs. The U.S. Department of Justice (DOJ) issued interim guidance in 1997 (62 FR 61344) and proposed regulations (63 FR 41662) in 1998. Final rules have not yet been issued.

The proposed DOJ regulations would require that both citizens and qualified aliens who are applying for Medicaid provide documentary evidence to verify their status. However, the proposed regulations would permit Federal benefit-granting agencies to establish alternative procedures for verifying citizenship. The agencies would be required (1) to publish regulations that provide for fair and nondiscriminatory procedures for verifying the citizenship of applicants for the benefit in question and (2) to obtain approval from the Attorney General for the alternative procedures.

CMS set forth its policy concerning self-declaration in a letter dated September 10, 1998, to State Medicaid directors. The letter explained that States may accept self-declaration of citizenship without

[8] Centers for Medicare & Medicaid Services, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage," Pub. No. 11000, Aug. 2001.

requiring submission of additional documentary evidence. On January 11, 2001, CMS published final regulations (42 CFR 457.320(c)) that permit States to accept self-declaration of citizenship for applicants applying for coverage under the State Children's Health Insurance Program, a State-run insurance program intended to provide health care coverage to certain low-income families.[9]

Evidence of Citizenship

The Department of Homeland Security (DHS), Bureau of Citizenship and Immigration Services is responsible for determining U.S. citizenship for persons in the United States.[10] Currently, DHS does not have a comprehensive list of acceptable evidence that may be used to document citizenship.

The CMS State Medicaid Manual contains two lists of evidence that may be accepted as proof of citizenship. These lists differ somewhat and neither is comprehensive. Examples of acceptable evidence listed in the manual include:

- Birth certificate,
- U.S. passport,
- Report of Birth Abroad of a Citizen of the United States, and
- Naturalization Certificate (INS Forms N-550 or N-570).[11]

In its operations manual, the Social Security Administration (SSA) provides additional sources of evidence that may be used to document U.S. citizenship for purposes of establishing eligibility for SSA-sponsored benefits.

See Appendix A for a listing of the evidence accepted by CMS or SSA to document U.S. citizenship.

Medicaid Eligibility Quality Control

Federal regulations require State Medicaid agencies to conduct posteligibility quality control activities to "eliminate or substantially reduce dollar losses resulting from eligibility errors."[12] From 1978 to

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[9] 66 FR 2490.

[10] Homeland Security Act of 2002 § 402(3).

[11] State Medicaid Manual, § 3212.3, "Methods of Documenting United States Citizenship."

[12] 42 CFR § 431.800.

1993, States were required to conduct "traditional" eligibility case reviews of the Medicaid-eligible population. As part of these traditional reviews, all States were required to review and verify elements such as citizenship and alienage, wage information, age, and residency. To verify information on citizenship, quality control staff were required to obtain documentation supporting the content of the declaration of citizenship.[13]

In 1994, CMS offered States three options for conducting Medicaid Eligibility Quality Control (MEQC). States could continue using traditional quality control, participate in a demonstration pilot program, or conduct quality control as part of a section 1115 waiver.[14] In fiscal year 2003, 39 States operated under a section 1115 waiver or an MEQC pilot.[15]

MEQC pilots. MEQC pilots allow States to develop innovative and targeted approaches for conducting quality control. Under pilots, States may tailor their programs to look at error-prone areas, high-dollar areas, or special populations. While operating under pilots, States are not required to conduct reviews of self-declaration of citizenship statements.

Section 1115 waivers. Under section 1115 waivers, States may allow certain kinds of deviations from their State Medicaid plans, including the expansion of eligibility for those who would otherwise not be eligible for the Medicaid program. Unless outlined in their contract with CMS, States operating under section 1115 waivers with quality control components are not required to conduct reviews of citizenship statements.

Related Benefit Programs

Other programs in which Medicaid recipients could potentially participate include Supplemental Security Income (SSI), Title IV-E foster care, and Temporary Assistance for Needy Families (TANF). We examined eligibility requirements and State policies and practices

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[13] State Medicaid Manual, Chapter III, 7269.130.

[14] CMS Medicaid Quality Control Program, http://www.cms.hhs.gov/medicaid/meqc/mqcguid.asp, accessed Jan. 22, 2004.

[15] Centers for Medicare & Medicaid Services, "National Overview of Medicaid Eligibility Quality Control for 2003," May 9, 2003.

regarding self-declaration of U.S. citizenship for these related programs in an effort to identify a potential resource for Medicaid staff. Throughout this report, we refer to the SSI, foster care, and TANF programs as "Medicaid-related programs."

SSI. In general, States are required to provide Medicaid coverage to recipients of SSI. SSA requires that

> all Supplemental Security Income (SSI) applicants alleging U.S. citizenship must submit evidence. However, if an individual actually provided proof of his/her citizenship status in a prior claim for benefits from SSA, he/she will not have to resubmit that evidence.[16]

Title IV-E foster care. Section 471(21) of the Act requires States to provide Medicaid or equivalent health insurance coverage to children eligible to receive Title IV-E foster care program maintenance funds. For all children receiving Federal foster care maintenance payments, States are required to verify citizenship or immigration status.[17]

TANF. Similar to Federal requirements related to documenting U.S. citizenship for Medicaid, current Federal law does not impose any specific documentation requirements, other than a signed declaration of U.S. citizenship, for TANF applicants claiming to be U.S. citizens.[18]

SCOPE

This inspection describes State practices to determine and document U.S. citizenship for Medicaid and related program eligibility, as well as State quality control activities. It does not identify the extent to which current Medicaid beneficiaries are ineligible on the basis of their citizenship. In addition, this inspection does not examine the extent to which eligible individuals fail to apply for Medicaid in States that require proof of U.S. citizenship as a condition of eligibility.

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[16] The SSA Program Operations Manual System, "Special Procedure for Establishing U.S. Citizenship for SSI Benefits," GN 00303.350, May 1995.

[17] "ACF Child Welfare Policy Manual – WC Policy Database – Policy Questions & Answers," Question 9, June 4, 2003.

[18] Social Security Act § 1137 (d)(1)(A).

METHODOLOGY

To identify States that allow self-declaration of U.S. citizenship for Medicaid and related programs, we gathered information from State Medicaid Directors and their staff responsible for quality control, as well as SSA officials, State foster care directors, and State TANF directors.

The data presented in this report were collected from State representatives in the 50 States and the District of Columbia. For reporting purposes, we refer to the District of Columbia as a State throughout our analysis.

State Medicaid Directors

To obtain descriptive information on all States' practices with regard to self-declaration of U.S. citizenship, we administered telephone surveys to all 51 State Medicaid directors and their staff. We asked directors about their States' self-declaration practices and whether their State has a policy instructing eligibility staff to obtain additional verification when applicants' statements appear incomplete, unclear, or inconsistent, which some States refer to as a "prudent person policy." We also asked directors to submit any evaluations or audits that were conducted within the last 5 years that looked at self-declaration of U.S. citizenship for Medicaid. We were able to speak with all directors during June and July 2003, giving us an overall response rate of 100 percent.

MEQC Supervisors/ Medicaid Directors

We administered another telephone survey to the 47 MEQC supervisors and/or Medicaid directors in States that permit self-declaration of U.S. citizenship during December 2003. We spoke with all 47 directors and/or supervisors in these States. Survey questions for the 47 Medicaid directors and/or supervisors focused on:

- Whether MEQC was conducted in a traditional format, under a section 1115 waiver, or under an MEQC pilot format during fiscal year 2003;
- The extent to which citizenship statements were checked during quality control activities;
- The types of documentation used to prove statements of U.S. citizenship; and

- Whether, as part of the States' quality control practices, self-declaration of U.S. citizenship was included for review.

For States operating a traditional MEQC program, we asked if staff conducted the required activities, as outlined in the CMS State Medicaid Manual.

CMS Representatives

We conducted interviews with representatives from the Medicaid State Operations group at CMS. These interviews focused on how States are permitted to conduct MEQC activities.

Social Security Administration Management Staff

In January 2004, we conducted a telephone interview with management staff at SSA to determine if statements of U.S. citizenship are documented during and throughout the Social Security enumeration process and for SSI benefits. We also asked questions on the extent to which citizenship data collected for SSA program eligibility are shared with State Medicaid agencies.

Foster Care Directors

We conducted a Web-based, self-administered survey of State foster care directors. All 51 directors responded to our survey during October 2003. The survey requested information on whether foster care staff document a child's U.S. citizenship when determining eligibility for federally funded foster care maintenance payments.

TANF Directors

We conducted a self-administered, Web-based survey of State TANF directors. All 51 directors responded to our survey during September 2003. The survey requested States' policies on self-declaration of U.S. citizenship to qualify for TANF benefits.

Citizenship Evidence Accepted by CMS or SSA

As mentioned earlier, DHS, the agency responsible for determining citizenship for a person in the United States, does not currently have a comprehensive reference list of acceptable evidence. In the absence of an official document from DHS, we developed a comprehensive list of "accepted evidence" by combining the evidence accepted by CMS[19] or

[19] State Medicaid Manual, §§ 3212.3 and 7269.130.

SSA[20] for purposes of documenting citizenship for program eligibility. We then compared the forms of evidence States report using to document U.S. citizenship for Medicaid and related programs with this comprehensive list. See Appendix A for a complete listing of accepted evidence used during our analysis.

We conducted this inspection in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency.

[20] The SSA Program Operations Manual System, "Establishing U.S. Citizenship for all SSA Programs," GN 00303.300, July 12, 2002.

FINDINGS

Forty-seven States allow self-declaration of U.S. citizenship for Medicaid; nearly all of these require evidence if statements seem questionable

Pursuant to the Act, States may accept a signed declaration as proof of U.S. citizenship from applicants seeking Medicaid benefits.[21] Forty-seven of fifty-one Medicaid directors report that their State allows or sometimes allows self-declaration of U.S. citizenship. For the four remaining States (Montana, New Hampshire, New York, and Texas) directors report that applicants must submit documentary evidence to verify U.S. citizenship statements. Table 1 displays each State's policy on self-declaration of U.S. citizenship for Medicaid.

Seven directors report that although their State sometimes allows applicants to self-declare U.S. citizenship, documentation is required under some circumstances. Four of these directors indicate that documentation is required for the aged, blind, and disabled populations. Other circumstances in which States sometimes ask for documentation include when the applicant was born outside of the United States or if information related to the applicant's place of birth does not exist in the State's vital statistics database.

With the exception of one State that verifies self-declaration statements through its vital statistics database, no other States volunteer that they obtain verification of citizenship statements from other nonapplicant sources. Further, none of the directors volunteer that eligibility staff currently utilize citizenship verification information from related programs such as TANF or foster care.

Nearly all States that allow self-declaration require evidence of U.S. citizenship if statements seem questionable during the eligibility process

Forty-four of the forty-seven States that permit or sometimes permit self-declaration report that they have a written or informal "prudent person policy" requiring documentation if the statements of the applicant seem questionable. Of these, 32 States have a written policy to guide staff in these situations. An example of a written policy instructs Medicaid eligibility staff that

[21] CMS letter to State Medicaid directors, September 10, 1998.

Table 1: State Policies on Self-Declaration of Citizenship for Medicaid

State	Allowed	Sometimes Allowed	Not Allowed	Prudent Person Policy
AL	✓			Written
AK		✓		Written
AZ	✓			Written
AR	✓			Informal
CA		✓		Written
CO	✓			None
CT	✓			Written
DE	✓			Informal
DC	✓			None
FL		✓		Written
GA	✓			Written
HI	✓			Informal
ID	✓			Informal
IL	✓			Informal
IN		✓		Informal
IA	✓			Written
KS	✓			Written
KY	✓			Written
LA	✓			Written
ME	✓			Informal
MD	✓			Written
MA	✓			None
MI	✓			Written
MN	✓			Written
MS		✓		Written
MO	✓			Informal
MT			✓	NA
NE	✓			Written
NV	✓			Written
NH			✓	NA
NJ		✓		Written
NM	✓			Written
NY			✓	NA
NC	✓			Written
ND	✓			Written
OH	✓			Written
OK	✓			Written
OR	✓			Written
PA	✓			Written
RI		✓		Informal
SC	✓			Written
SD	✓			Informal
TN	✓			Informal
TX			✓	NA
UT	✓			Written
VT	✓			Written
VA	✓			Informal
WA	✓			Written
WV	✓			Written
WI	✓			Written
WY	✓			Written
Totals	40	7	4	-
Written	-	-	-	32
Informal	-	-	-	12
None	-	-	-	3

Source: OIG analysis of State policies on self-declaration of U.S. citizenship, 2004

> when statements of client are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker shall obtain additional verification before eligibility is determined.

The remaining 12 States have unwritten, informal prudent person policies requiring additional verification when eligibility staff deem statements questionable.

Medicaid directors report they allow self-declaration to increase access and express concern about increased costs if the policy is prohibited

We asked the 47 State Medicaid directors in States allowing self-declaration their reasons for not requiring evidence of U.S. citizenship. Twenty-five respondents say that they have been encouraged by CMS to simplify their application processes in order to reduce barriers to health care access. In addition, 17 respondents report that through their posteligibility quality control activities, they have not seen a problem with self-declaration of citizenship.

We asked what costs, if any, Medicaid applicants would incur if all were required to provide documentary evidence of U.S. citizenship. Twenty-eight of forty-seven directors report that it would delay eligibility determination. In addition, 25 directors comment that it would result in increased eligibility personnel costs. Twenty-one directors also report that it would be burdensome and/or expensive for applicants to obtain copies of birth certificates or other documentation.

Twenty-seven States do not verify the accuracy of U.S. citizenship claims as part of their posteligibility quality control activities

Federal regulations require State Medicaid agencies to conduct posteligibility quality control activities to "eliminate or substantially reduce dollar losses resulting from eligibility errors."[22] States may conduct MEQC activities in a traditional format, under an MEQC pilot format, or as part of a section 1115 waiver. In fiscal year 2003, 27 of the 47 States that allow self-declaration did not conduct quality control activities that included verification of statements of U.S. citizenship.

[22] 42 CFR § 431.800.

Of the 20 States that did review statements of U.S. citizenship, 9 did so for a nonrepresentative sample of the entire Medicaid population. Consequently, some groups that may pose vulnerability to Medicaid integrity were not included in the sample of applications that were reviewed. See Appendix B for a list of States' quality control activities.

Three States operating traditional MEQC programs do not conduct required quality control activities

Under traditional MEQC, States are required to verify that sampled applicants are U.S. citizens. Three of the eleven States that operated a traditional MEQC program and allowed self-declaration in fiscal year 2003 did not conduct required eligibility quality control for U.S. citizenship. These States report that they did not collect documentary evidence to support statements of U.S. citizenship for sampled applicants. (See Table 2.)

Table 2: Medicaid Quality Control on Self-Declaration of U.S. Citizenship by Type of MEQC Program

Type of MEQC Program	Does Not Conduct MEQC for Self-Declaration	Conducts MEQC for Self-Declaration	Total Number of States That Allow Self-Declaration
Traditional	3	8	11
Pilot*	20	8	28
Waiver	4	4	8
Overall total States	**27**	**20**	**47**

*In fiscal year 2003, Tennessee operated under both an MEQC pilot and an 1115 waiver. We considered Tennessee a pilot program because it conducted MEQC activities under its pilot, which included the entire Medicaid population.

Source: OIG analysis of State MEQC practices, 2004

Twenty MEQC pilot States do not monitor self-declaration of U.S. citizenship

While operating under an MEQC pilot, States may, but are not required to, conduct posteligibility reviews of self-declaration of citizenship statements. Twenty of the twenty-eight States that permit self-declaration of U.S. citizenship and operated under a pilot program in fiscal year 2003 did not obtain documentary evidence to support beneficiaries' statements of U.S. citizenship for any portion of their Medicaid population. Eight States conducted quality control on self-declarations of citizenship, but seven did so for a nonrepresentative sample which accounted for less than 8 percent of the Medicaid population. These samples did not include certain populations that may pose vulnerability to Medicaid integrity.

Four section 1115 waiver States do not address self-declaration of U.S. citizenship

While operating under a section 1115 waiver with a quality control component, a State may, but is not required to, conduct reviews of self-declaration of citizenship statements. Four of the eight States that allow Medicaid applicants to self-declare U.S. citizenship and operated under section 1115 waivers in fiscal year 2003 did not obtain and verify documentary evidence to support statements of U.S. citizenship. Of the four section 1115 waiver States that verify statements of U.S. citizenship for quality control purposes, two conducted MEQC for only a subset of the entire Medicaid population.

Only one State reports conducting an audit looking at self-declaration of U.S. citizenship, and it found vulnerabilities

We asked States for any quality control audits or evaluations that looked at self-declaration of citizenship. Only one State director provided an audit on this topic. This audit report found vulnerabilities related to the process of self-declaration of U.S. citizenship.

Specifically, the audit, conducted in January 2002 by the Secretary of the State of Oregon, found that the State provided full Medicaid benefits to 25 beneficiaries (of the sample of 812) who were noneligible noncitizens. The audit report concludes that there are potential risks involved in allowing applicants to self-declare their U.S. citizenship on mail-in applications, which do not allow workers to verify the accuracy of statements of U.S. citizenship. They estimate

that the risk could result in an annual cost of about $2 million, based on a 1 percent estimate of noneligible noncitizens receiving Medicaid benefits.[23]

Some States use types of evidence that are not accepted by CMS or SSA to document citizenship for Medicaid

Four States use forms of evidence that are not accepted by CMS or SSA to document citizenship for initial Medicaid eligibility

As reported earlier, seven States sometimes allow and four States do not allow Medicaid applicants to self-declare citizenship. Of these 11 States, 4 use types of evidence to document citizenship that are not accepted by CMS or SSA. Specifically, two States allow the use of a school record to document citizenship and two allow use of a family Bible as documentation.[24]

Seven of eleven States that sometimes allow or do not allow self-declaration report accepting documentation that is accepted by CMS or SSA. These include public birth records, U.S. passports, and naturalization certificates.

Thirteen States use types of evidence that are not accepted by CMS or SSA to verify statements of U.S. citizenship for posteligibility quality control purposes

Thirteen of the twenty States that report conducting quality control to verify statements of U.S. citizenship use forms of documentation that are not accepted by CMS or SSA. For example, 11 of these 13 States report using records of receipt of SSI to verify citizenship. While one of the primary sources included in the CMS State Medicaid Manual to verify citizenship and alienage declarations is "Record of receipt of

[23] Audit Report: "Department of Human Services Oregon Health Plan Eligibility Review," Report No. 2002-03, January 3, 2002, p. 1.

[24] According to section 7269.1 of the State Medicaid Manual, States may accept evidence of continuous residence in the United States prior to June 30, 1948. Among the records accepted to prove continuous residence are school records, a marriage license, a voter registration card, an insurance policy, military service records, and a Social Security number. The directors identified here did not report accepting documentation that was dated prior to June 30, 1948.

SSI,"[25] in discussions with SSA, we found that verification of receipt of SSI does not guarantee that the Medicaid applicant or beneficiary is a U.S. citizen. Medicaid agencies must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files, which provide States with eligibility, payment, and demographic data relating to SSI recipients, to substantiate that evidence of U.S. citizenship was submitted for SSI eligibility purposes.

Other examples of documentation that is not accepted by CMS or SSA but which State Medicaid directors report using for quality control purposes are voter registrations, proof of Medicare Part A, school records, children's birth certificates to prove a parent's citizenship status, marriage licenses, and even other self-declaration statements.

Medicaid-related programs are more likely to document citizenship; their verifications may be a useful resource for Medicaid

Medicaid applicants may potentially participate in related programs such as SSI, foster care, and TANF. We found that these related programs are more likely than Medicaid to document citizenship and most often use evidence that is accepted by CMS or SSA to verify this status. These verifications may be a useful resource for Medicaid staff. Appendix C provides information on related programs' policies and use of documentation on a State-by-State basis.

United States citizenship is always documented for enumeration and SSI

The SSA officials report that all applicants must provide documentary evidence of U.S. citizenship or legal status in order to receive a Social Security number (enumeration) or to qualify for SSI benefits. In some cases, SSA's prior determination of citizenship is accepted as a means for documenting U.S. citizenship. However, SSA is currently reviewing this policy to ensure that it does not rely on inadequate documentation that was submitted for purposes of enumeration and SSI in prior years.

As indicated earlier, in discussions with SSA officials, we found that verification of receipt of SSI does not prove U.S. citizenship.

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[25] It is important to note that this list does not distinguish between appropriate sources to verify U.S. citizenship versus appropriate sources to verify alienage.

Eligibility staff must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files.

Forty-two States document the citizenship status of children receiving Title IV-E foster care benefits, as required by the Administration for Children and Families

The Administration for Children and Families requires that foster care eligibility staff document U.S. citizenship status for purposes of federally funded Title IV-E foster care maintenance payment eligibility.[26] Forty-two of fifty-one foster care directors report that staff document U.S. citizenship when determining eligibility for federally funded foster care maintenance. Seven directors report that staff sometimes document U.S. citizenship, and two say citizenship is never documented.

Among the seven foster care directors who indicate that U.S. citizenship is sometimes not documented, circumstances under which no documentation occurs vary significantly. Examples include "the rare occurrence when a child falls under category 85, undocumented alien emergency situation coverage" and "when a parent or other reliable source reports a child is a citizen."

Fifteen States document citizenship to determine TANF eligibility

Similar to requirements for Medicaid, States may permit TANF applicants to self-declare U.S. citizenship status as a condition of eligibility. Fifteen of fifty-one directors report verifying citizenship for TANF eligibility. Twelve directors report that it is their State's policy to sometimes verify applicants' statements of U.S. citizenship. Twenty-four TANF directors report that their State allows self-declaration for eligibility purposes.

Related programs commonly use types of evidence that are accepted by CMS or SSA to verify citizenship

Thirty-five of the forty-nine foster care directors that verify or sometimes verify U.S. citizenship for children entering their State's foster care program use types of evidence that are accepted by CMS or SSA. The remaining 14 include forms of documentation that are not accepted. Examples of these include green cards, Social Security

[26] "ACF Child Welfare Policy Manual – WC Policy Database – Policy Questions & Answers," Question 9, June 4, 2003.

numbers, citizenship declarations by parents/caregivers, military service records, and family Bibles.

Twenty of the twenty-seven States that verify or sometimes verify U.S. citizenship for TANF eligibility purposes use evidence accepted by CMS or SSA. The remaining States report using evidence that is not accepted, such as voter registration cards, school records, and/or family Bibles.

In the majority of instances, we found that related programs draw on evidence that is accepted by CMS or SSA to verify statements of citizenship. In States where related programs both verify statements of citizenship and use generally accepted documentation to do so, these verifications may be a useful resource for Medicaid.

RECOMMENDATIONS

We recognize that there are challenges in providing Medicaid benefits expeditiously while ensuring the accuracy of eligibility determinations. By their nature, self-declaration policies have inherent vulnerabilities in that they can allow applicants to provide false statements of citizenship. As such, it is vital to have protections in place to prevent such practices.

Based on the descriptive information we collected from States, we conclude that existing safeguards at the point of entry into Medicaid and during posteligibility quality control could allow false statements of citizenship to go undetected. Below are three recommendations for improving safeguards:

CMS should strengthen posteligibility quality controls in States that allow self-declaration

Currently, 47 States allow self-declaration of citizenship for Medicaid. Over half of these never verify citizenship statements as part of their posteligibility quality control procedures. In States that do check statements, most do so for a subset of the entire Medicaid population. More examinations are needed to determine if there are problems resulting from this policy. Therefore, CMS should encourage States that allow self-declaration of citizenship to conduct reviews on the accuracy of these statements. Findings from these reviews could then be used to determine the extent to which this policy results in inaccurate eligibility determinations.

CMS should issue a complete list of evidence that States may reference when determining eligibility

Four of the eleven States that require or sometimes require evidence of citizenship for initial Medicaid eligibility use types of evidence that are not accepted by CMS or SSA. Further, 13 of the 20 States that report conducting quality control to verify statements of citizenship use types of evidence that are not accepted by CMS or SSA. In its State Medicaid Manual, CMS has two lists of evidence that are slightly different, and neither is comprehensive. To better ensure that States collect evidence that is consistent with CMS standards, CMS should issue a complete list of evidence that States may reference when determining eligibility.

CMS should explore allowing State Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource

When looking at related programs including SSI, Title IV-E, and TANF, we found that these programs are more likely to verify citizenship as a condition of eligibility and, in most cases, use types of evidence that are accepted by CMS or SSA. If CMS determines it appropriate, States that allow applicants to self-declare citizenship could perform checks on the accuracy of these statements using related programs' verification information. This step would not add a burden to applicants and would not require the collection of additional documentation. In Appendix C, we identify which States and programs verify statements of citizenship and use evidence accepted by CMS or SSA.

AGENCY COMMENTS

CMS concurred with our recommendations. The agency further commented that it has already taken steps to improve safeguards to prevent applicants from providing false statements of citizenship. The full text of CMS's comments is included in Appendix D.

We note several issues with CMS's current efforts. Specifically, CMS explained that, pursuant to Federal regulations, States must verify statements of citizenship for sampled active cases as part of their posteligibility quality control procedures. We reiterate that this regulation applies only to States that operate traditional quality control. States that operate under a pilot or a section 1115 waiver with a quality control component are not required to verify all elements of eligibility, including statements of citizenship as part of their posteligibility case file review.

CMS also commented that States choosing to accept self-declaration of citizenship need to have systems in place for some type of posteligiblity check to ensure that the self-declaration procedure is reliable. CMS stated that it is taking steps to do this by requiring a review of the accuracy of eligibility determinations as part of the Payment Error Rate Measurement (PERM) project. Currently, the Office of Management and Budget is working with CMS to define the scope of the PERM project. As of June, no decision has been made regarding the inclusion of errors related to Medicaid eligibility determinations.

APPENDIX ~ A

Types of Evidence Accepted by CMS or SSA to Document U.S. Citizenship		
Documentation Type	**CMS**	**SSA**
A birth certificate showing birth in the United States	✓	✓
Religious record of birth recorded in the United States or its territories within 3 months of birth, which indicates a U.S. place of birth	✓	✓
United States passport	✓	✓
Form FS-240 (Report of Birth Abroad of a Citizen of the United States)	✓	✓
Form FS-545 (Certification of Birth)	✓	✓
U.S. Citizen I.D. Card Form I-97 (United States Citizen Identification Card)	✓	✓
Form N-550 and N-570 (Certificate of Naturalization)	✓	✓
Forms N-560 and N-561	✓	✓
Evidence of continuous residence in the United States prior to June 30, 1948 (including school records; marriage license; voter registration card; insurance policy; military service records; Social Security number issued prior to June 30, 1948, etc.)	✓	
Record receipt of SSI*	✓	✓
Bureau of Vital Statistics, local government, hospital, or clinic records of birth and parentage	✓	
Court records of parentage, juvenile proceedings, or child support	✓	

Sources: CMS State Medicaid Manual §§ 3212 and 7269 and the SSA Program Operations Manual System: GN 00303.300

Documentation Type	CMS	SSA
American Indian Card (first issued by INS in 1983)	✓	✓
Form DS-1350 (Certification of Report of Birth) issued by the State Department		✓
Northern Mariana Identification (NMI) Card, first issued by INS in 1987, to identify naturalized citizens born in the NMI before November 3, 1986	✓	✓
Evidence of civil service employment by the U.S. Government before June 1, 1976		✓

Sources: CMS State Medicaid Manual §§ 3212 and 7269 and the SSA Program Operations Manual System: GN 00303.300

*Note: In discussions with SSA, we found that verification of receipt of SSI alone does not guarantee that the Medicaid applicant or beneficiary is a U.S. citizen. Medicaid agencies must take the additional step of verifying the Alien/Refugee code in the State Data Exchange report files. Therefore, while CMS does accept this form of documentation, we determined that this might not prove U.S. citizenship.

APPENDIX ~ B

Fiscal Year 2003 MEQC in the 47 States Allowing Self-Declaration of U.S. Citizenship		
State	**CMS MEQC Categorization**	**Conducts Some MEQC On Self-Declaration Of U.S. Citizenship**
Alabama	Traditional	Yes
Alaska	Pilot	No
Arizona	Waiver	Yes
Arkansas	Waiver	Yes
California	Pilot	Yes
Colorado	Pilot	No
Connecticut	Traditional	Yes
Delaware	Pilot	No
District of Columbia	Pilot	No
Florida	Traditional	Yes
Georgia	Traditional	No
Hawaii	Waiver	Yes
Idaho	Pilot	No
Illinois	Pilot	Yes
Indiana	Pilot	Yes
Iowa	Pilot	No
Kansas	Pilot	No
Kentucky	Pilot	No
Louisiana	Pilot	No
Maine	Traditional	No
Maryland	Waiver	Yes
Massachusetts	Waiver	No
Michigan	Traditional	Yes
Minnesota	Waiver	No
Mississippi	Traditional	Yes
Missouri	Waiver	No
Nebraska	Pilot	No

A P P E N D I X ~ B

State	CMS MEQC Categorization	Conducts Some MEQC On Self-Declaration Of U.S. Citizenship
Nevada	Pilot	No
New Jersey	Pilot	No
New Mexico	Pilot	No
North Carolina	Pilot	No
North Dakota	Traditional	Yes
Ohio	Pilot	No
Oklahoma	Traditional	No
Oregon	Waiver	No
Pennsylvania	Pilot	Yes
Rhode Island	Traditional	Yes
South Carolina	Pilot	Yes
South Dakota	Pilot	No
Tennessee	Pilot*	Yes
Utah	Pilot	Yes
Vermont	Traditional	Yes
Virginia	Pilot	No
Washington	Pilot	No
West Virginia	Pilot	No
Wisconsin	Pilot	Yes
Wyoming	Pilot	No
Total Traditional	11	-
Total Pilot	28	-
Total Waiver	8	-
Total Yes	-	20
Total No	-	27

Source: OIG analysis of State MEQC practices, 2004

*In fiscal year 2003, Tennessee operated under both an MEQC pilot and an 1115 waiver. We considered Tennessee a program because it conducted MEQC activities under its pilot, which included the entire Medicaid population.

APPENDIX ~ C

Related Programs Policies on Self-Declaration and Their Use of Documentation Accepted by CMS or SSA: A Guide for Medicaid Eligibility Staff					
State	Medicaid	TANF	TANF Uses Evidence Accepted by CMS or SSA	Foster Care	Foster Care Uses Evidence Accepted by CMS or SSA
AL	▲	Δ	Yes	●	No
AK	Δ	Δ	Yes	●	Yes
AZ	▲	Δ	No	●	Yes
AR	▲	▲	NA	●	Yes
CA	Δ	●	Yes	●	Yes
CO	▲	▲	NA	●	Yes
CT	▲	Δ	No	Δ	No
DE	▲	●	No	●	Yes
DC	▲	▲	NA	●	Yes
FL	Δ	▲	NA	●	No
GA	▲	▲	NA	●	No
HI	▲	●	Yes	●	No
ID	▲	▲	NA	●	No
IL	▲	Δ	Yes	●	Yes
IN	Δ	●	Yes	●	Yes
IA	▲	Δ	Yes	●	Yes
KS	▲	▲	NA	●	Yes
KY	▲	▲	NA	●	No
LA	▲	▲	NA	Δ	Yes
ME	▲	▲	NA	●	Yes
MD	▲	Δ	Yes	●	Yes
MA	▲	Δ	No	▲	NA
MI	▲	Δ	Yes	●	Yes
MN	▲	▲	NA	▲	NA
MS	Δ	▲	NA	●	Yes
MO	▲	Δ	Yes	Δ	Yes
MT	●	●	Yes	●	Yes
NE	▲	▲	NA	●	No

APPENDIX C

State	Medicaid	TANF	TANF Uses Evidence Accepted by CMS or SSA	Foster Care	Foster Care Uses Evidence Accepted by CMS or SSA
NV	▲	●	Yes	●	Yes
NH	●	●	No	●	Yes
NJ	Δ	●	No	Δ	Yes
NM	▲	▲	NA	Δ	No
NY	●	●	Yes	●	Yes
NC	▲	▲	NA	●	No
ND	▲	●	Yes	Δ	No
OH	▲	●	Yes	●	Yes
Ok	▲	▲	NA	●	Yes
OR	▲	▲	NA	●	Yes
PA	▲	Δ	No	●	Yes
RI	Δ	●	Yes	●	Yes
SC	▲	▲	NA	●	Yes
SD	▲	▲	NA	●	Yes
TN	▲	▲	NA	●	Yes
TX	●	●	Yes	Δ	No
UT	▲	▲	NA	●	No
VT	▲	Δ	Yes	●	Yes
VA	▲	▲	NA	●	Yes
WA	▲	▲	NA	●	Yes
WV	▲	▲	NA	●	Yes
WI	▲	●	Yes	●	Yes
WY	▲	●	Yes	●	No
Total ▲	40	24	-	2	-
Total Δ	7	12	-	7	-
Total ●	4	15	-	42	-
Total Yes	-	-	20	-	35
Total No	-	-	7	-	14
Total NA	-	-	24	-	2

Source: OIG analysis of related program policies on self-declaration of U.S. citizenship, 2004

* Because SSA always verifies the citizenship status of applicants for a Social Security number or for SSI, a State-by-State description of this policy does not appear in this table.

▲ Denotes a State that reports permitting self-declaration of U.S. citizenship or reports not requiring evidence of citizenship to qualify for federally funded benefits.

Δ Denotes a State that reports sometimes permitting self-declaration of U.S. citizenship.

● Denotes a State that reports never permitting self-declaration or requiring evidence of U.S. citizenship to qualify for this federally funded benefit.

APPENDIX ~ D

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

RECEIVED
2005 APR 12 PM 3:50
OFFICE OF INSPECTOR GENERAL

DATE: APR - 8 2005

TO: Daniel R. Levinson
Acting Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Self-Declaration of U.S. Citizenship for Medicaid" (OEI-02-03-00190)

Thank you for the opportunity to review and comment on the above OIG draft report. OIG reviewed the extent to which states allow self-declaration of U.S. citizenship for Medicaid and related programs and identified potential vulnerabilities associated with quality control activities and evidence used to verify citizenship.

States must provide Medicaid to all United States citizens who otherwise meet the eligibility criteria of the state's Medicaid program. Aliens' eligibility for full Medicaid coverage is limited to certain "qualified aliens." Per section 1137(d) of the Social Security Act, states must require, as a condition of eligibility, a declaration in writing, signed under penalty of perjury, that an applicant is a citizen or national of the United States. Pursuant to that statutory provision, the Centers for Medicare & Medicaid Services (CMS) permits states to accept applicants' self-declaration of citizenship, but also to require further verification, if necessary. This flexible policy allows states to enroll eligible individuals while preserving program integrity. It is in line with a larger effort promoted by CMS to help states simplify the Medicaid application process.

As there are inherent challenges in trying to provide Medicaid benefits expeditiously, while still ensuring the accuracy of eligibility determinations, OIG conducted this review. We appreciate OIG's efforts. OIG's findings reinforced our policy approach. The 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. The review also recommended steps for improving safeguards that CMS and states have already undertaken.

The OIG's draft report provided three specific recommendations for improving safeguards. Those recommendations and our responses are as follows.

OIG Recommendation

The CMS should strengthen post-eligibility quality controls in states that allow self-declaration.

CMS Response

We concur. We agree that states should have strong post-eligibility quality control activities in place in order to reduce losses from all eligibility errors, including self-declaration of citizenship. In fact, CMS' Medicaid Eligibility Quality Control regulations require states to verify that the state properly determined the citizenship status of sampled active cases. Pursuant to Federal regulations at 42 CFR 431.812(e), states "must collect and verify all information necessary to determine the eligibility status of each individual included in an active case selected in the sample as of the review month and whether Medicaid payments were for services which the individual was eligible to receive."

The report does not find particular problems regarding false allegations of citizenship, nor are we aware of any. However, we believe that, as with self-declarations of income, states that accept self-declaration of citizenship need to have systems in place for some type of post-eligibility check to ensure that the self-declaration procedure is reliable. CMS is taking steps to have states strengthen post-eligibility controls by requiring a review of the correctness of eligibility determination under the proposed Payment Error Rate Measurement regulation, published on August 27, 2004. In the absence of any indication that there are improper self-declarations, we do not think we need to do more at this time. The CMS also will reiterate its policy at the 2005 fall meeting of the National Association of State Medicaid Directors.

OIG Recommendation

The CMS should issue a complete list of evidence that states may reference when determining eligibility.

CMS Response

We concur. For states that choose to require documentation of applicants' citizenship, CMS has provided a list of acceptable documentation in its State Medicaid Manual, which is posted on its Web site. The U.S. Citizenship and Immigration Services (formerly the Immigration and Naturalization Service) recently published a regulation containing a longer list of documentation that states may use. The CMS currently references that regulation on its Web site, but will adopt the OIG's recommendation and post the new list per se. In addition, at the time we publish our next State Medicaid Manual update, we will include the new list.

Page 3 – Daniel R. Levinson

OIG Recommendation

The CMS should explore allowing state Medicaid staff to use citizenship verifications from other Medicaid-related programs as an additional resource.

CMS Response

We concur. This recommendation reinforces our current approach, which permits states to accept citizenship verification from other programs. We articulated the principle of permitting states to accept other programs' determinations with respect to particular eligibility requirements in our Guide to Medicaid eligibility, "Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage." We will provide technical assistance to states that request it.

While OIG's report reinforces our current policy approach to provide states with the flexibility to enroll eligible individuals while preserving program integrity, we will follow up on OIG's recommendations as stated above.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Acting Regional Inspector General for Evaluation and Inspections in the New York Regional Office. Other principal Office of Evaluation and Inspections staff who contributed include:

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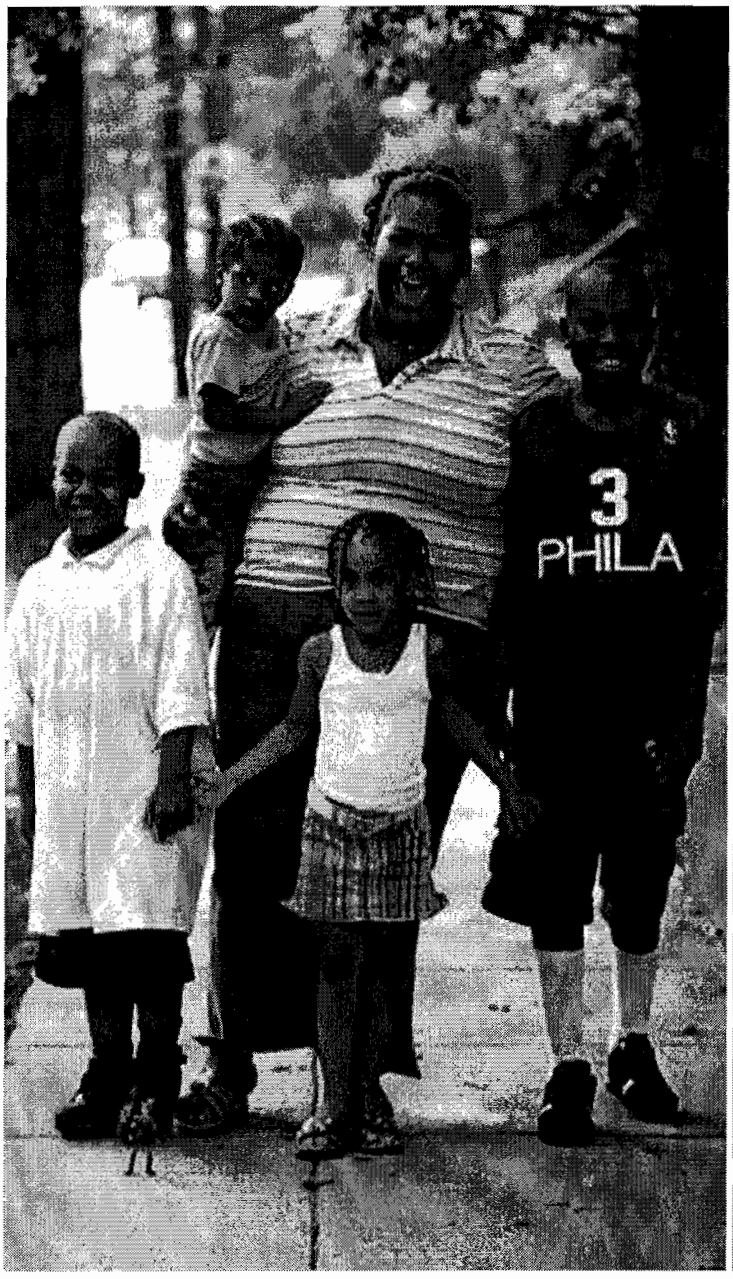
Working Together for Health

MEDICAID ANNUAL REPORT
FY 2005

Government of the
District of Columbia
Anthony A. Williams, Mayor

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION



Working Together for Health

MEDICAID ANNUAL REPORT FY 2005

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

Quality Health Care for Vulnerable Populations

A Message from the Director, Department of Health

I WANT TO EXPRESS MY CONGRATULATIONS TO THE MANAGEMENT AND STAFF of the Medical Assistance Administration for the progress they have made over the last year in ensuring the provision of a wide range of quality health services to the residents of the District of Columbia. The Department of Health is proud to be the agency to carry out the Mayor's vision of providing quality health services for the most vulnerable populations of the District of Columbia.

"We are on our way to making D.C. one of the healthiest cities in the country."

Medicaid services are essential for the over 140,000 residents (one in four District residents) who are served every month through the program. The breadth of services encompasses the entire spectrum of our population, from the newborns to our senior citizens. Through sound management and oversight, we continue to ensure that comprehensive health services are provided to our members.

This annual report on Medicaid services in the District is a testimony to all of you who work with the Department of Health and Medicaid to ensure we meet the health needs of our citizens. We are on our way to making D.C. one of the healthiest cities in the country.

Gregg A. Pane, MD
Director, Department of Health

Our Responsibility to Over 140,000 Residents

A Message from the Medicaid Director

OVER THE PAST TWO YEARS, THE DISTRICT OF COLUMBIA'S MEDICAID PROGRAM HAS FOCUSED on becoming a world-class health insurance program. New programs to provide care for those most in need have been developed, eligibility for Medicaid has been expanded, collaborative community, advocacy and provider relationships have been established, and fiscal integrity has been restored. I am proud of all of the Medicaid staff and their desire to ensure that our Medicaid recipients get the best possible health care.

The Medicaid budget will approach $1.4 billion in FY 2006. We serve over 140,000 of the District's residents—one of every four residents—a number that continues to grow every month. We do not take this responsibility lightly. We are committed to working closely with the Mayor's office, with the Council, and with sister agencies to ensure that quality care is provided in a coordinated and effective manner.

"We are committed...to ensure that quality care is provided in a coordinated and effective manner."

Our program provides a wide variety of benefits and services for our beneficiaries. Children, parents, childless adults and elders are all eligible to receive services from the Medicaid program. Over 90,000 of our beneficiaries are served through our managed care organizations (MCOs). To ensure quality of care in these programs, we have worked closely with the National Committee for Quality Assurance (NCQA). To maintain NCQA accreditation, plans must meet high standards of quality that are measured for ongoing improvement. We are requiring our MCOs to become members of NCQA, a nationally recognized organization, to ensure better quality reporting and oversight. Additionally, we have instituted a process for them to report annually on 41 nationally recognized quality measures. As you can see, we view quality of health care as an extremely important part of our service to our beneficiaries.

We continue to increase our efforts to work closely with other District government health providers, establishing waivers and state plan amendments to increase access to Medicaid services in other settings. This provides our beneficiaries with a continuity of care that heretofore has not been available. We are also increasing the scope and breadth of home and community-based services that are available, so that institutionalization is not the only option, and individuals who choose to live at home can now do so.

As you read through this report you will see evidence that many new initiatives are making Medicaid a better program for our District residents. I would be remiss if I did not thank the Mayor, the District Council, and the Department of Health and our community partners for their support of our efforts. It has been my pleasure to oversee this program for the past two years and I look forward to even greater achievements in the year ahead.

Robert T. Maruca, Medicaid Director and
Senior Deputy Director, Medical Assistance Administration
Department of Health

Highlights of Fiscal Year 2005 and a Look to 2006

THE MEDICAID PROGRAM IN FY 2005

■ **Enrollment.** In FY 2005, Medicaid enrollment averaged 141,941 people a month, or one quarter of the District's population. Enrollment increased over 2%. See page 5.

■ **Spending.** For the fiscal year ended September 30, 2005, Medicaid spending for health care was $1.26 billion, up 3.4% (preliminary data). Payment per enrollee per month was $741, up 1.3%. See page 7.

■ **Economic impact.** 92% of Medicaid payments are made to health care providers in the District. Medicaid also brings in about $900 million a year in federal funding to D.C. See page 17.

HIGHLIGHTS OF FY 2005

■ **New initiatives to help HIV-positive people stay healthy.** D.C. became the first Medicaid program to cover costly anti-retroviral drugs for HIV-positive people who are not yet sick enough to qualify for Medicaid under standard eligibility rules. The District also received a federal "Ticket to Work" grant so that HIV-positive people can keep Medicaid coverage while maintaining employment. See page 10.

■ **More emphasis on managed care quality.** Medicaid began requiring its three managed care organizations to report results on 41 nationally accepted measures of quality. In FY 2006, all MCOs will be required to seek accreditation by the National Committee for Quality Assurance. See page 8.

■ **Improved child immunization rates.** D.C. was one of two Medicaid programs nationwide that exceeded federally set goals for child immunization. See page 11.

■ **Increased recoveries.** Medicaid efforts to reduce fraud and abuse, to ensure that Medicaid is the insurer of last resort, and to claim rebates from drug manufacturers all resulted in increased dollar recoveries. See page 18.

■ **Eligibility simplified.** The Medicaid eligibility form was streamlined from 18 pages to 6 pages. See page 6.

MAJOR ISSUES AND INITIATIVES FOR FY 2006

■ **Expansion in coverage and federal funding.** D.C. has requested federal approval to expand Medicaid coverage to include 1,700 people now covered by the D.C. Health Care Alliance. The expansion would generate $19.0 million a year in new federal funding and free up District money that could be used to fund health care for other needy groups. See page 6.

■ **Implementation of the Medicare drug benefit.** On January 1, 2006, Medicare will implement its new drug benefit. For 16,000 D.C. Medicaid beneficiaries, Medicare will pay for drugs now paid for by Medicaid. We are working with Medicare, beneficiary advocates and provider associations to ensure a smooth transition. See page 11.

■ **Increased flexibility in home and community-based services (HCBS).** A new Medicaid initiative will give people receiving home and community-based services more autonomy in selecting the services they need and in choosing their caregivers. HCBS is a cost-effective program that helps people remain at home when their health conditions otherwise would require placement in an institution. See page 14.

■ **Value purchasing for prescription drugs.** In FY 2006, Medicaid intends to become a more effective purchaser of prescription drugs by implementing a preferred drug list and changing drug payments to reflect maximum allowable cost (MAC) benchmarks. See page 19.

Essential Health Care for D.C. Residents

An overview of the residents that Medicaid serves and the services provided.

AN ESSENTIAL PROGRAM FOR D.C. RESIDENTS

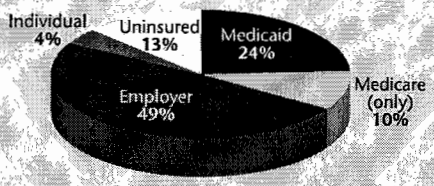
■ **2005 marks the 40th anniversary** of Medicaid and Medicare, two programs that have done enormous good for many millions of people who otherwise would have gone without health care coverage due to age, poverty or disability.

■ **Serving more D.C. residents every year.** In the 2005 fiscal year that ended September 30, D.C. Medicaid served an average of 141,941 residents a month. Since many beneficiaries moved on and off Medicaid during the year, the number of people served at various points during FY 2005 was even higher.

■ **How Medicaid fits in.** When it comes to health insurance, almost everyone in the U.S. comes under one of five categories.

- *Employment-based coverage* is the foundation of the system. When employers offer health plans, they pay an average of 75% of the cost, which now exceeds $10,000 a year for family coverage.[1] Unlike wage income, employees do not have to pay taxes on the health benefits they receive. But more and more employers do not offer health plans, especially to new hires, part-time workers or workers earning under $15 an hour.[2]
- *Medicare* is available for people age 65 and over, regardless of income, and for people with certain disabilities that prevent them from working.
- *Individually purchased insurance* is bought by a few people, but is very expensive.
- *Medicaid* primarily serves low-income children and their parents, people with disabilities, and low-income Medicare beneficiaries.
- *The uninsured population* tends to include childless couples, single men and others who do not come under Medicaid eligibility categories, as well as people whose income exceeds Medicaid thresholds but who don't have access to employment-based coverage.

D.C. Health Insurance Coverage, 2003



Medicaid percentage includes 3% eligible for both Medicaid and Medicare.
Source: ACS Government Healthcare Solutions

■ **The second-largest source of insurance.** Medicaid covers about one-quarter of the D.C. population in an average month. About half the D.C. population has employment-based coverage.[3] See the chart on this page.

■ **Critical for kids.** Medicaid covers 44% of D.C. kids age 18 and under while employment-based plans cover 43%, according to the Kaiser Commission on Medicaid and the Uninsured.[4]

Medicaid Population Demographics FY 2005

	Number	%
By Sex		
Male	57,185	40%
Female	84,756	60%
By Age		
17 and under	71,427	50%
18–21	9,019	6%
22–64	49,639	35%
65 and over	11,856	8%
By Race		
Black	124,181	87%
White	2,214	2%
Other	15,546	11%
By Ward		
1	15,218	11%
2	20,864	15%
3	1,649	1%
4	15,009	11%
5	18,969	13%
6	16,676	12%
7	24,199	17%
8	28,841	20%
Unknown	516	0%
TOTAL	**141,941**	**100%**

Note: Percentages may not sum to 100% due to rounding.

The Federal Poverty Line

Medicaid eligibility often depends on annual family income relative to the federal poverty line (FPL). This table shows the 2005 FPL.

Family Size	100% of FPL	150% of FPL	200% of FPL
1	$9,570	$14,355	$19,140
2	$12,830	$19,245	$25,660
3	$16,090	$24,135	$32,180
4	$19,350	$29,025	$38,700

CHANGES IN ELIGIBILITY

■ **Eligibility form simplified.** In FY 2005, the application for Medicaid benefits was reduced from 18 pages to 6 pages. The extra pages had been used to check for unusual sources of income and assets that rarely affected eligibility.

■ **Innovative waiver program will expand coverage.** In FY 2006, Medicaid intends to extend coverage to three groups of people:

- About 900 disabled people with incomes between 100% and 200% of the federal poverty line (FPL)
- About 300 19- and 20-year-olds
- About 500 unborn children of pregnant immigrant women

These groups are now covered by the D.C. Health Care Alliance, the program for the uninsured that is 100% funded by the District. Medicaid has requested federal approval to make these groups eligible for Medicaid, which is 70% funded by the federal government. The increase in Medicaid spending is expected to be about $27 million a year, mostly for the people with disabilities who have chronic health care needs. The inflow of federal money will free up District funds that can be used to fund health care for other needy groups. The new beneficiaries will be eligible for a broader range of services than they are now. By extending coverage to unborn children, Medicaid can fund prenatal care for low-income immigrant women. Prenatal care is among the most cost-effective ways to improve the health of the D.C. population, especially since many of these children become eligible for Medicaid at birth.

■ **Plan to expand benefits for dual eligibles.** Medicaid has requested federal approval to simplify eligibility standards for people dually eligible for Medicaid and Medicare. Currently, some Medicare beneficiaries can obtain full Medicaid benefits if their incomes are under 100% of the FPL. For another group of Medicare beneficiaries, Medicaid will pay their Medicare Part B premiums if their income is between 100% and 120% of the FPL, though they do not receive full Medicaid benefits. The plan is to increase both thresholds to 150% of the FPL, benefiting about 150 people at a total cost of about $200,000 a year.

Medicaid Spending by Fiscal Year Ending Sept. 30

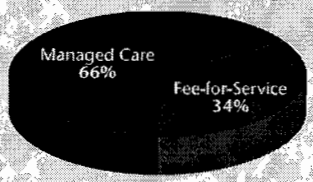
	FY 2004 Actual	FY 2005 Preliminary	FY 2006 Budgeted
Spending for Care	$1,221,035,000	$1,262,424,000	$1,337,198,000
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	$732	$741	$769

Note: The FY 2006 enrollee count assumes the same growth rate as was seen between FY 2004 and FY 2005. It is not an official MAA projection.

MEDICAID SPENDING AND SERVICES

■ **Spending trends.** Medicaid spending for care was $1.26 billion (preliminary data) in FY 2005, making Medicaid the largest item in the D.C. budget.[5] The increase over FY 2004 was 3.4%, reflecting a 2.1% increase in average monthly enrollment and a 1.3% increase in spending per enrollee per month. The 1.3% figure compares very well with the nationwide 9.2% increase in the average cost of an employment-based health plan.[6]

Medicaid Enrollment FY 2005
141,941 Monthly Average

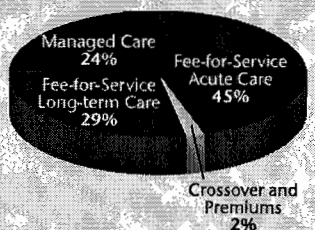


■ **A foundation of managed care.** Of total average enrollment of almost 142,000 people, about 94,000 are enrolled in managed care in a typical month. These beneficiaries are typically children and working age adults without disabilities. About one-quarter of the Medicaid budget is spent purchasing care for this group.

■ **Care for the elderly and people with disabilities.** The 48,000 beneficiaries not enrolled in managed care plans are typically elderly and/or disabled, with heavy health care needs. About 45% of the budget is spent on their physician visits, hospital care, prescription drugs and other acute care services. In addition, they are more likely to need long-term care, which accounts for about 29% of the budget.

■ **The most important payer for long-term care.** Medicaid is by far the largest payer for long-term care, which includes nursing facility care, home health care, personal care attendants and other home and community-based services. Private-sector plans rarely cover these services, while Medicare's long-term care benefits are much more limited than those of Medicaid.

Medicaid Spending FY 2005
$1.26 Billion (Preliminary)



■ **A big help to poor and ill Medicare beneficiaries.** About 16,000 D.C. residents are eligible for both Medicare and Medicaid. Medicaid is the major payer for their long-term care and prescription drug needs and also pays much of their Medicare cost-sharing obligations. About 2% of the budget is spent on Medicare premiums and cost-sharing amounts on "crossover" claims.

■ **Spending outlook.** Medicaid spending in FY 2006 is budgeted at $1.34 billion, a 5.9% increase from FY 2005.

■ **Continued budget pressure.** Over the longer term, federal actuaries predict that Medicaid spending nationwide will outpace growth in national health spending. One factor—expected to account for about one-fifth of Medicaid spending growth—is the double-digit growth in home and community-based services, which allow elderly people and those with disabilities to remain at home instead of living in institutions.[7]

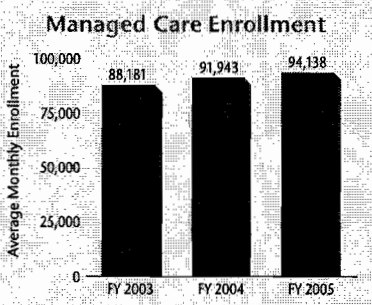
Managing Care for Health and Cost Control

Two-thirds of D.C. Medicaid beneficiaries receive health care from one of four managed care plans. Medicaid is taking strong steps to ensure the quality of care for plan beneficiaries.

■ **Medicaid managed care.** In 1994 the District began a major effort to promote managed care. In 1997, the District moved to mandatory enrollment for certain eligibility groups. Today, two-thirds of Medicaid enrollees belong to one of four managed care plans: AMERIGROUP, D.C. Chartered Health Plan, Health Right, and Health Services for Children with Special Needs (HSCSN).

■ **Managed care organizations.** AMERIGROUP, D.C. Chartered Health Plan and Health Right are managed care organizations (MCOs) that accept clinical and financial responsibility for almost all Medicaid services provided to their members, who are typically children and their non-disabled family members in the 21–64 age group.

■ **Special plan.** HSCSN manages care for children with disabilities. Medicaid beneficiaries enroll voluntarily in HSCSN; enrollment averaged 3,375 children a month in FY 2005. HSCSN is not at financial risk for the care its members receive. The plan is accredited by the Joint Commission on Accreditation of Healthcare Organizations.



■ **Improving coordination of substance abuse care.** Outpatient care for substance abuse is one of the few services that the MCOs do not provide. Instead, this care is 100% funded by the D.C. government. In FY 2005, MAA requested federal approval to make outpatient care for substance abuse a Medicaid service, which would bring $3.0 million a year in new federal funding to the District. In addition to improved integration with other care received by MCO members, the change is expected to increase access to services, including residential substance abuse treatment for pregnant women.

■ **Expansion of MCO membership.** Several years ago, the District began enrolling childless adults 50 to 64 years old in Medicaid, so long as their incomes were below 50% of the federal poverty line. (This required a waiver of federal eligibility rules.) In FY 2005, this group of 1,362 people became MCO members. These beneficiaries will benefit from improved coordination of care.

■ **MCO quality to be evaluated using 41 measures.** In FY 2005, D.C. began requiring MCOs to collect and report standardized quality measures, such as child immunization rates, breast cancer screening rates and customer satisfaction scores. "This is a huge step towards expanding our quality improvement efforts by measuring performance on a richer set of standards," said Dr. Gregg Pane, Director of the Department of Health, in announcing the initiative. The measures are from the nationally recognized Health Plan Employer Data and Information Set (HEDIS), thereby enabling Medicaid and the MCOs to track quality of care over time and in comparison with national benchmarks.

■ **NCQA accreditation.** In FY 2006, Medicaid will require all MCOs to seek accreditation by the National Committee for Quality Assurance (NCQA). The NCQA, a national, not-for-profit organization, is often described as the watchdog of managed care. Teams of NCQA experts will visit each MCO to evaluate it on patient safety, service, confidentiality and other quality standards.[8]

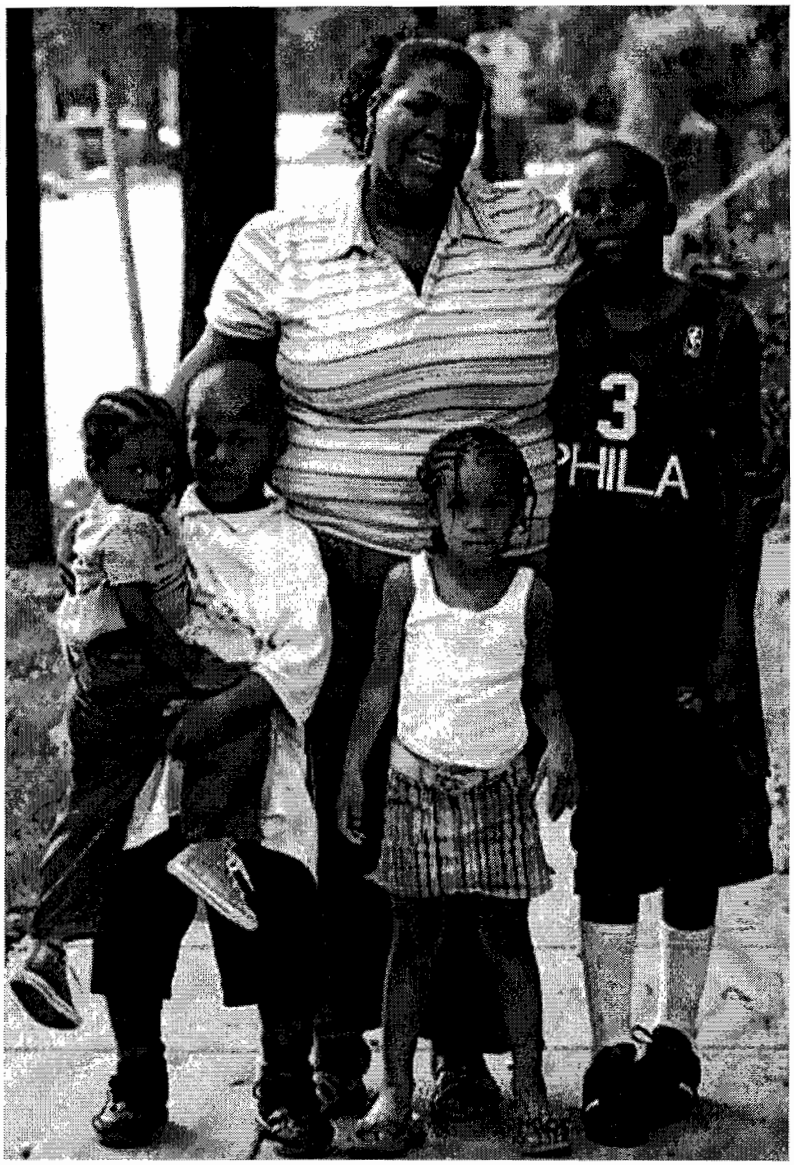
Carole Colbert and Family

"I thank God for Medicaid," says Carole Colbert, whose six children have all benefited from Medicaid coverage. Today, Ms. Colbert is raising her daughters Jewel, 2, and Aniya, 5, her son, Randy, 7, and her grandson Demetrius, 11.

Growing up was not easy for Ms. Colbert and her two siblings, who were raised by a single mother addicted to alcohol. As Ms. Colbert explains, "Mom didn't teach us about the 'birds and the bees,' so when I was coming up, I was always the one in trouble."

Pregnant at the tender age of 14, Ms. Colbert's children are as old as 27 and as young as 2. As Ms. Colbert explains, "Medicaid was always there to help."

Reflecting on an early experience with her oldest daughter, Ora, now 22 years old, Ms. Colbert recalls: "One day, Ora was just walking on the grass, and she twisted her leg on a piece of metal that was stuck in the grass." Ora had to be rushed to the hospital for knee surgery. "If it wasn't for Medicaid," she says, "I'd still be paying for it today."



Carole Colbert with daughters Jewel and Aniya, son Randy, and grandson Demetrius.

She also recalls a brief instance when she and her children experienced an interruption in coverage when she had to get recertified by Medicaid. During the recertification process, one of her kids needed medical attention. "After I spoke to the representative and explained my family situation," says Ms. Colbert, "Medicaid got me back on the program quickly. Medicaid is always on time."

"Just think, if my kids didn't get shots, they would not be in school."

Ms. Colbert also remembers what Medicaid was like before the District began working with managed care organizations to provide better access to quality health care. Ms. Colbert's family is enrolled in D.C. Chartered Health Plan and she sees the benefits for herself and her children today. "Before Chartered," she explains, "my children and I would miss doctors' appointments because I couldn't afford to get to the doctor, or I was too sick to get there. Once Chartered came along, they provided transportation for me and my kids so that I can take them to get their shots. Just think, if my kids didn't get shots, they would not be in school," Ms. Colbert says.

As a stay-at-home single parent with young children, Ms. Colbert needs to maintain her health. Medicaid has covered two surgical procedures for Ms. Colbert, including emergency surgery for a hernia. More recently, though, Ms. Colbert's primary care physician referred her to a specialist to manage other health problems. "When I think about the surgery I've needed and that I need to see a specialist, I would have been pulling my hair out to pay for this because no one is going to take me without Medicaid." Ms. Colbert concludes: "Just imagine if I didn't have Medicaid."

Here for Health

When Congress enacted Medicaid 40 years ago, the program looked more like a welfare program than a health program. Today, Medicaid provides insurance for over 41 million Americans, giving it a central place in the health care system. D.C. Medicaid sees its role as improving the health of District residents, often in collaboration with other agencies. In this section we describe a dozen such initiatives.

■ **Medicaid beneficiaries gain from Medicare disease management program.** In FY 2005, D.C. was selected to participate in Medicare Health Support, a demonstration program designed to improve health outcomes and reduce costs for people with multiple chronic diseases. About 1,600 D.C. residents dually eligible for Medicare and Medicaid can choose to participate in Medicare Health Support, which was previously called the Chronic Care Improvement Program. Participation is free. In D.C., the program is managed by American Healthways, a national disease management company selected by Medicare. Depending on their needs, participants may receive nurse counseling, home monitoring equipment, home visits and intensive case management. MAA's role in the demonstration is to help with outreach to beneficiaries and providers and to assist with data analysis.

■ **Standardized child health screening form will improve care.** In FY 2005, Medicaid piloted a standardized form for HealthCheck, the District's program to make sure every child gets early screening and treatment for health problems. (HealthCheck is the D.C. version of the national Medicaid program called EPSDT.) Medicaid collaborated with physicians and managed care plans to develop a new standardized medical record form for HealthCheck. The form, which is completed by the primary care provider, is designed to capture all aspects of a well-child visit, including the need for additional services such as dental or specialty care. The form will be fully implemented early in FY 2006. The District will become the only Medicaid program to have a centralized child health registry accessible to providers and managed care plans. The registry will enable MAA to make sure HealthCheck services take place. As well, authorized providers will be able to view a child's history of immunizations and preventive health care visits. This picture of a child's health status will enhance MAA's ability to perform quality of care analysis with providers. MAA also plans to incorporate lead-poisoning data in the registry in the near future.

Innovative Programs Help Keep HIV-Positive People Healthy

On January 14, 2005, D.C. became the nation's first Medicaid program to cover critical yet costly anti-retroviral drugs for HIV-positive patients with incomes below 100 percent of the federal poverty line (FPL). The result: 267 people get needed coverage and preventive services before they become disabled. Another program provides some HIV-positive people with high-quality home water filters, which screen out bacteria that can be fatal to immune-compromised patients. Both initiatives required waivers of federal Medicaid rules.

A third program, called "HIV Ticket to Work Independence," allows an average of 420 HIV-positive people a month to keep their Medicaid coverage even if employment raises their incomes up to 300% of the FPL. Ticket to Work, which is 95% funded by the federal government, started in April 2005.

These programs help HIV-positive people stay healthy and remain in the workforce as long as possible, thereby contributing to the District's economic development.

■ **Drug utilization review (DUR) board works for appropriate medication use.** The DUR board, comprising D.C. physicians and pharmacists, works to improve quality of care, which is especially an issue for beneficiaries with complex conditions who may receive several drugs prescribed by different physicians. Since Medicaid claim files provide an overview that no individual physician has, the board draws on these records to create and review 400 patient profiles a month. The focus is on potential issues related to drug-drug interactions, drug-disease interactions, and over- and under-utilization of medications. If a potential issue is deemed significant then the prescribing physician is alerted. The board also undertakes four educational campaigns a year targeted at physicians. In FY 2005, these campaigns focused on resistance to antibiotics, coronary artery disease, diabetes and congestive heart failure.

■ **Interagency collaboration to improve health of D.C. residents.** Better delivery of health care services sometimes requires better coordination of services. That was the conclusion of MAA and several other D.C. agencies that signed a July 2005 Memorandum of Understanding. Parties to the memorandum included the Department of Health, Department of Mental Health, Department of Child and Family Services, Department of Youth Rehabilitation Services, Maternal and Child Health Administration, Addiction Prevention and Recovery Administration, and the D.C. Public Schools. The intended results are increased efficiency, increased interagency data sharing, and better coordination of services.

Impact of the New Medicare Drug Benefit on Medicaid Beneficiaries

On January 1, 2006, about 77,000 Medicare beneficiaries in D.C. will become eligible for Medicare's new Part D prescription drug benefit. For residents who are dually eligible for Medicare and Medicaid, Medicare will start paying for the prescription drugs that Medicaid has paid for in the past. About 16,000 dually eligible beneficiaries will be affected.

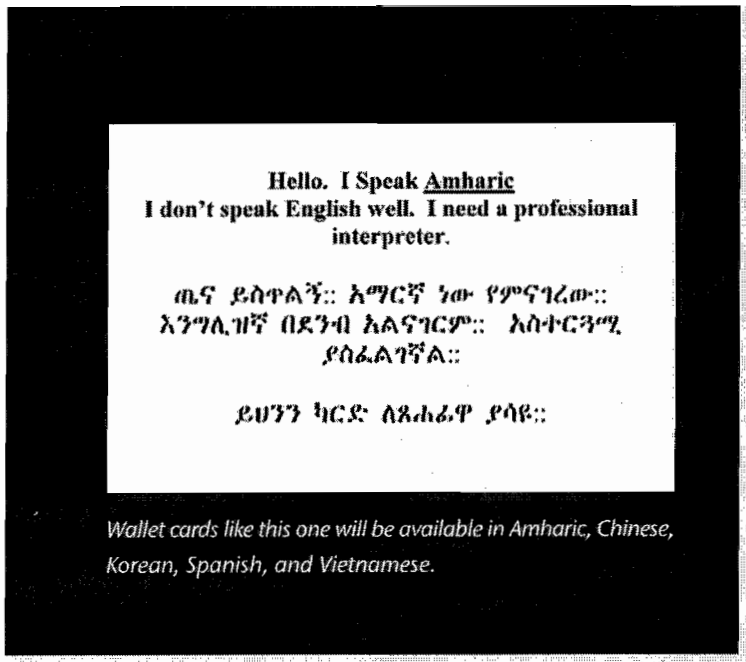
Our top priority is that Medicaid beneficiaries have no interruptions in the supply of essential medications. MAA is partnering with an extensive network of providers, pharmacists and advocacy groups to assist beneficiaries in making the transition. We are participating in educational forums for health care professionals, advocates and the public about this new and important benefit. We are also sharing information with beneficiaries through direct mail updates.

The new Medicare Part D benefit applies only to prescription drugs provided through pharmacies. Drugs provided to Medicaid beneficiaries in hospitals, physician offices, dialysis clinics and other settings are unaffected.

Beneficiaries and providers with questions about the new Medicare benefit can find information at www.cms.hhs.gov, www.medicare.gov and 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

■ **D.C. exceeds child immunization goal.** In June 2005, D.C. was recognized as one of two Medicaid programs nationwide that exceeded its child immunization goal under the federal Government Performance and Results Act of 1993. Working in collaboration with managed care plans, Medicaid providers, community-based organizations, and the Office of Immunization's Vaccines for Children Program, MAA increased the Medicaid immunization rate from 63% in October 2000 to 73% in October 2004, exceeding the original goal of 72% for children under two years old. The D.C. Medicaid immunization rate for school-age children is 95%.

■ **Focusing on childhood obesity.** Recognizing the increasing need to prevent obesity from an early age, participating managed care plans conducted a study to establish baseline data on obese and overweight children and youth. As a result of the study, MAA developed guidelines for the identification of care for obese/overweight children, adopted mandatory screening of two-year-olds to assess obesity/overweight symptoms based on height, weight and body mass index, developed an appropriate model for treatment, and trained managed care practitioners on the treatment model in June 2005. To ensure continued refinement of these efforts, MAA established the Obesity Prevention Advisory Committee, comprising D.C. agencies, the public schools, and community stakeholders.



Wallet cards like this one will be available in Amharic, Chinese, Korean, Spanish, and Vietnamese.

■ **Reaching out to non-English speaking communities.** Overcoming language barriers and improving communication is critical to increasing access to health care for the District's diverse population. Medicaid collaborated with community groups to develop a culturally sensitive brochure about beneficiaries' rights to interpreter services for health care. The brochure was field-tested to ensure wide acceptance among non-English speakers. In FY 2006, the brochure will be made available in Amharic, Chinese, Korean, Spanish, and Vietnamese, which, other than English, are the most prevalent languages spoken in the D.C. schools. In the past, no similar information had been provided to non-English speakers.

■ **Getting kids to the dentist.** Access to dental care for low-income children is a problem across the U.S., with fewer than 20% of Medicaid children having an annual dental visit.[7] Using a combination of focus groups, health fair participation, and increased outreach efforts in partnership with managed care plans, D.C. Medicaid boosted its rate from 20% in FY 2003 to 32% in FY 2004. (The FY 2005 rate is not yet available.) To maintain the momentum, MAA implemented a dental helpline in FY 2005 to help beneficiaries locate providers and intends to improve access by increasing fees paid to dentists in FY 2006.

■ **Preventing deaths from the flu.** The District of Columbia reported only one flu-related death in FY 2005, thanks in part to Medicaid's successful efforts to make flu shots available using the house call system despite limited supplies. Not one Medicaid beneficiary died of flu-related causes.

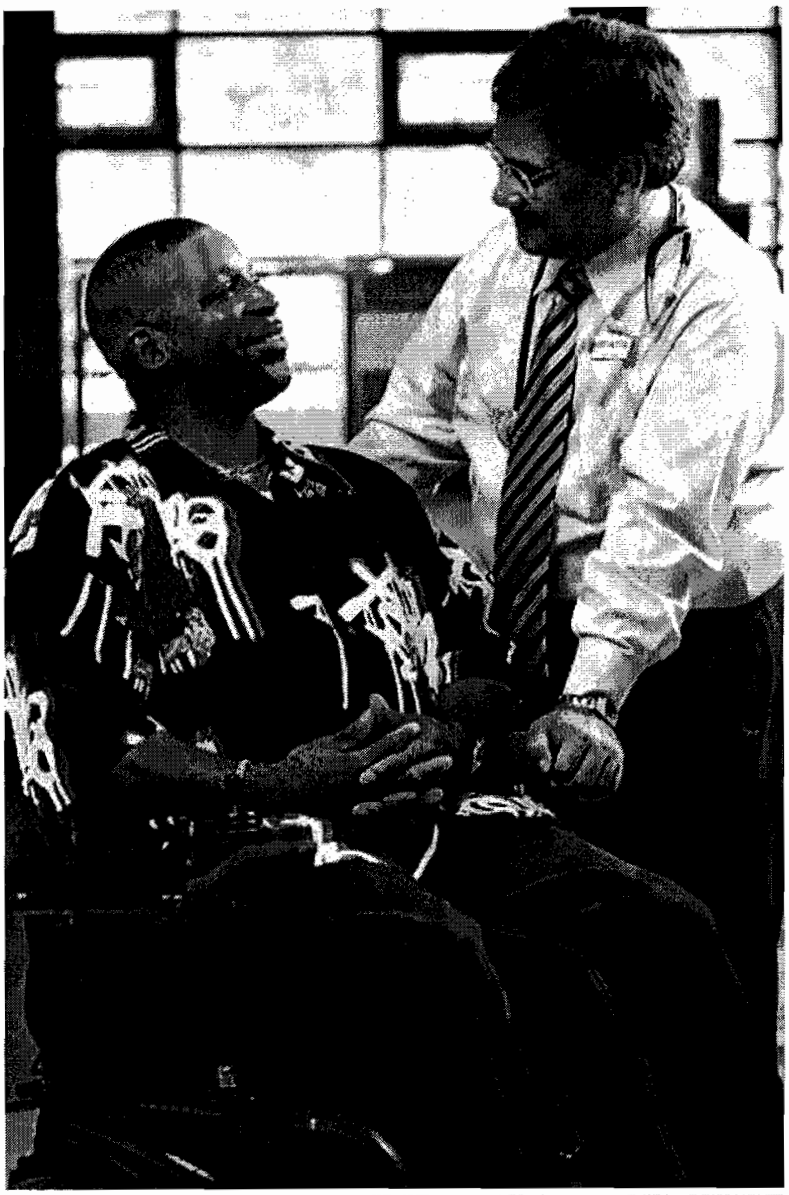
■ **Ensuring the confidentiality of beneficiaries' health information.** MAA was one of 10 District agencies involved in a citywide effort to upgrade policies, procedures and business processes to improve the security of beneficiaries' confidential health information. In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), all MAA staff members now receive training in how to properly handle protected health information. In FY 2006 and FY 2007, MAA and other agencies will be working to implement additional HIPAA regulations designed to protect confidential health information.

Vincent Massey

Vincent Massey, then 35 years old, was washing his car when he was shot once in the leg and twice in the lungs. One bullet ricocheted inside his chest and lodged in his spine, where it remains today, seven years later. At that instant, his lower abdomen and legs became paralyzed. The drive-by gunman was never identified.

At D.C. General Hospital, a staff member had Mr. Massey fill out the forms that would qualify him for federal Supplemental Security Income and D.C. Medicaid benefits. He was transferred to the National Rehabilitation Hospital on Irving St. NW, which treated both the physical and mental after-effects. "When you get a jolt like that—losing your legs—you go through a depressive period," he says now. A hospital psychiatrist helped him get through it. Rehabilitation "built my morale up."

At first, he used an ordinary wheelchair. It made a big difference when a doctor said he needed a motorized chair. "It allowed me to just be normal. I don't have to stay in the house," he says. Rather than "watching TV, my mind going nowhere," Mr. Massey gets out every day, riding the Metro, going to appointments and visiting friends and family. He goes out so much that his wheelchair needs regular repairs. He also benefits from a stander, a device that helps him stand up, exercise his muscles, and avoid serious problems such as pressure sores.



Vincent Massey with his doctor, Sandeep Simlote, at the National Rehabilitation Hospital.

With therapy, he has regained some use of his lower abdomen and legs. Before, he couldn't move so much as a toe and he needed incontinence garments. Now, he can lift his feet off the footrests, reposition himself from the chair to a bed, and take himself to the bathroom. "I can move—things I couldn't do before," he says.

Last year the rehabilitation hospital asked Mr. Massey to participate in a study on investigational drugs to decrease involuntary muscle tightness. He undergoes four hours of tests each week. "I'm giving back for what's been given to me," he says.

"I'll put it this way... It (Medicaid) takes a broken person and makes him feel whole."

From here, Mr. Massey's goal is to move from his room in a group home into his own apartment, get a job, and continue improving his ability to move. "Hopefully, some day in the near future I'll be able to donate this chair to someone less fortunate," he says. "That's my goal." For now, he tells people how lucky he is. "I like to talk to people, to tell people how good God has been to me. Every day I feel grateful."

Except for the research study, which is paid for under a grant, Medicaid has paid for all of Mr. Massey's care. "I'll put it this way," he says of Medicaid. "It takes a broken person and makes him feel whole." Without Medicaid, "people like me wouldn't have a chance."

Helping People Who Need Long-Term Care

Medicaid is the leading funding source for long-term care across the U.S., covering services such as nursing facility care for the elderly, residential care for people with developmental disabilities, and home-based assistance with the activities of daily living. To the greatest extent possible, the goal is to tailor care to fit each person's medical, social and physical situations.

■ **Flexible, cost-effective programs allowed 815 people to live at home instead of in institutions.** D.C. Medicaid operates two programs that fund home and community-based services (HCBS) for people who otherwise would have to live in institutions. Since this care costs less than institutional care, the federal government has waived otherwise-applicable rules so that beneficiaries can receive services designed for their specific needs. The HCBS program may pay for assistance with daily activities like eating and dressing, wheelchair ramps, a supportive living environment such as a group home, or occasional institutional care to give family caregivers a respite.

In FY 2005, the HCBS program for elderly people and people with physical disabilities served an average of 408 beneficiaries a month, up from 197 in FY 2004. These beneficiaries otherwise would typically be living in a nursing facility. The HCBS program for people with mental retardation and developmental disabilities served an average of 407 beneficiaries per month, an increase from 397 in FY 2004. These beneficiaries otherwise would be living in an intermediate care facility.

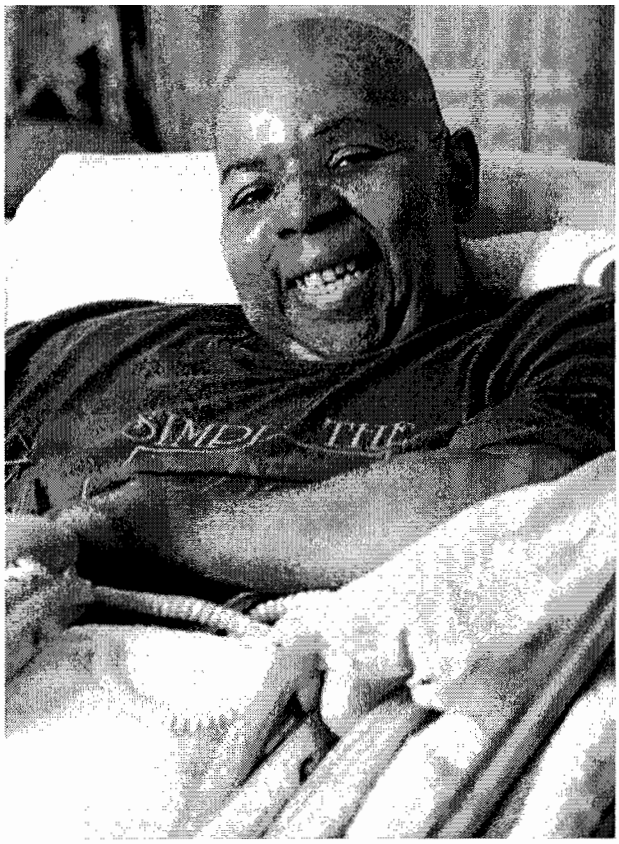
■ **Robert Wood Johnson grant will evaluate innovative D.C. program.** The prestigious Robert Wood Johnson Foundation awarded a grant to compare the Medical House Call Program (MHCP) with other ways of serving recipients of home and community-based services. The Medical House Call Program coordinates all home, hospital and community-based care through home visits to beneficiaries with chronic illnesses and limited mobility. (One participant is Mimi D. Atkins; see page 15.) The goal is to avoid unnecessary emergency room visits, hospitalizations, and nursing home placements. Results from the evaluation will help improve the program and potentially expand it. The evaluation grant will be managed by MAA and administered through a partnership that includes the Washington Hospital Center MHCP, Unity Health Care (a new house call program based on the Washington Hospital Center model), and the Delmarva Foundation, the quality improvement organization for D.C. Medicaid.

■ **New nursing facility payment method designed to boost access.** A new way of paying nursing facilities is intended to improve access to care and keep D.C. residents closer to home. Contingent upon federal approval, nursing facilities will be paid more for patients with greater care needs and less for patients with fewer care needs. Patient care needs will be measured using Resource Utilization Groups (RUGs), a clinical algorithm also used by Medicare and several other Medicaid programs. MAA's previous payment method was based on each facility's costs per day of patient care. These cost-based rates were capped and they didn't vary by patient, so patients with more expensive needs often had to be placed in facilities outside the District to get the care they needed.

■ **Consumer-directed care in home and community-based services.** A new initiative will give about 100 beneficiaries more flexibility in the home and community-based services they receive. Called "consumer-directed care," the initiative will give beneficiaries flexibility within a defined budget to decide which services they need to live as independently as possible. They will also have more involvement in selecting their personal care attendants and other caregivers. In FY 2006, consumer-directed care will become available to beneficiaries in the HCBS program for elderly people and people with physical disabilities.

■ **Improved access to services under the MR/DD waiver.** To improve access to home and community-based services for beneficiaries with mental retardation and developmental disabilities, MAA changed the rules to allow individual occupational therapists and speech/language pathologists to provide services. Previously, therapists had to be employees of an agency, which reduced the availability of providers.

Mimi D. Atkins



At first, Mimi D. Atkins didn't pay much attention to occasional back pain. It was the 1970s, and she was working at St. Elizabeth's Hospital as a nursing assistant, taking care of people with mental illness. But the pain got worse, and then her doctor said she had rheumatoid arthritis. It was a bad case. By 1979, she had to quit after 10 years at St. E's. As the illness progressed through the 1980s, she had both knees replaced, and she relied more and more on a wheelchair. By about 1990, the inflammation, deformity and pain in her joints meant she was bedridden.

Since the 1970s, BlueCross BlueShield insurance has continued to pay for her physician care, drugs, and occasional hospitalizations. But BlueCross, like virtually all commercial insurance plans, doesn't cover the costs of long-term care. Ms. Atkins's mother was her primary caregiver, turning her in bed, preparing her meals, bathing her and keeping her company.

In 2001, Ms. Atkins was hospitalized with blood clots, which typically form in leg veins and can be fatal if they break away and travel to the lungs. Hospital staff "talked to me about going to a nursing home until I got better. I said I didn't want to do it."

It was obvious that Ms. Atkins's mother, herself approaching 80, couldn't continue to care for her. Medicaid would pay for nursing facility care after Ms. Atkins exhausted her life savings, which, because of the cost of nursing facility care, usually doesn't take long. Instead, a doctor suggested Medicaid's program of home and community-based services (HCBS), which is designed to allow patients like her to stay at home as long as possible. Ms. Atkins applied for Medicaid and was accepted, but she wasn't yet old enough to qualify for the HCBS program. She was on a waiting list for over a year.

"I wouldn't be able to stay at home if it wasn't for Medicaid."

Today Ms. Atkins, now 60, and her mother still share one of D.C.'s classic brick row houses. Ms. Atkins's electrically controlled bed is in the former dining room. Family photos are on the living room mantle, and her mother sits on the porch to greet visitors and neighbors. Medicaid pays for a personal care aide 16 hours a day. The aide fixes her meals, bathes her, and turns her every two hours.

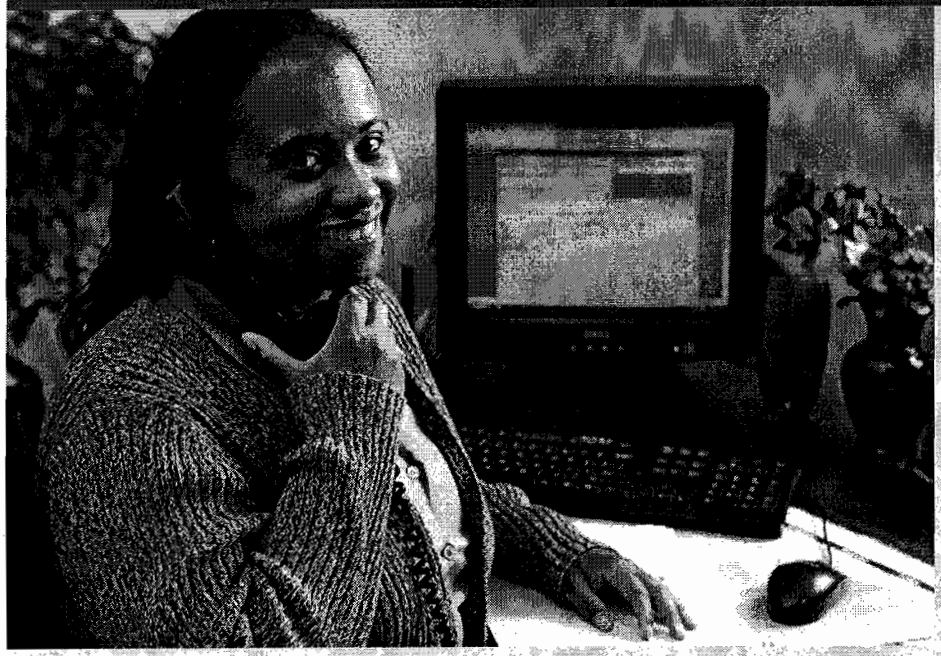
"I read, I have friends that call me every day, I have television of course, I talk to my aides and they talk to me, which is a godsend," she says. "I do a lot of things." Her lap is her desk, where she reads her mail and pays her bills. At night, she can press an alarm button to summon help or an ambulance if needed. She says she's doing well. "Life is what you make of it. I choose to be happy, the way I am right now."

Ms. Atkins also participates in an innovative program funded by Medicaid. Called the Medical House Call Program, its goal is to prevent unnecessary emergency room visits, hospitalizations and nursing facility placements. When a person can't walk, pressure sores, infections, blood clots and depression are constant threats to life, health and the ability to stay at home. Individual circumstances—how their home is arranged, how well they're eating, their activities—affect their physical and mental health. Under the Medical House Call Program, a nurse practitioner and a social worker, both specially trained, visit Ms. Atkins each month. A physician visits at least quarterly. They take 45 to 60 minutes to check her head to toe. Thankfully, and amazingly, she has had no problems with pressure sores. They also monitor her congestive heart failure, a serious illness that has been very well controlled.

"I wouldn't be able to stay at home if it wasn't for Medicaid," Ms. Atkins says. "They really help a lot, and I'm grateful for that. It's a blessing, really."

The D.C. Resource Center

Navigating the Maze of Long-Term Care Options



Resource center supervisor Angelique Calhoun assigns care managers to do individualized assessments of what's best for each individual.

When you can no longer live at home on your own, the options are baffling. Home health care, assisted living, nursing facility? Pay as you go, Medicare, Medicaid, private insurance? What's the difference? What's best for your situation?

Now, there's a one-stop answer. In January 2005, the D.C. Resource Center for Aging and Persons with Disabilities opened at 2311 Martin Luther King Avenue, near the Anacostia Metro stop. The public can drop in to the pleasant renovated home, call the center at 202-204-3540, or email inquiries to acalhoun@dcresourcecenter.com. A website is planned for the coming year.

About 100 people ask for help each month, and that number will grow as the word spreads. Sometimes the resident makes an inquiry; sometimes it is a family member or friend. They might learn about the resource center from its booth at a health fair or have been referred by a seniors' group or a health care provider. For some residents, life has changed suddenly because of a stroke or a fall; for others, they're just finding it harder and harder to live at home on their own.

A receptionist asks for basic information, then a professional staff member calls back within four hours. When appropriate, one of the center's three care managers will visit the home for a complete assessment, at no charge. "What medical conditions do you have? Can you walk on your own? Are loose rugs a hazard? Does a neighbor check in?" are typical questions.

Though placement in a nursing facility may be the best option for the resident, it's often possible for people to continue living in the community so long as they get a bit of help. Options include personal care attendants, skilled nursing care at home, modifications such as wheelchair ramps, or moving to an assisted living facility. Many of these services are covered by Medicaid's home and community-based services (HCBS) program.

To cut red tape, an eligibility worker from the D.C. Income Maintenance Administration is on site at the resource center. A resident can apply right there for Medicaid and the HCBS program. The eligibility worker even helps people apply for other D.C. programs such as food stamps and cash assistance for people with disabilities or families with children. When residents aren't eligible for Medicaid, care managers can advise them on other options such as Social Security, Medicare, subsidized housing and grant programs. At all times, the goal is to help residents navigate the maze of programs that might help them live as independently and as happily as possible.

Partnerships with Providers

In a typical month, 4,300 providers provide services to Medicaid beneficiaries—everything from a wheelchair van for a doctor's appointment to heart surgery at one of D.C.'s top hospitals. MAA and its contractors work to do a good job serving the providers who serve our beneficiaries.

■ **Managed care and fee-for-service.** For about 94,000 beneficiaries, Medicaid pays managed care plans, and then the plans pay physicians, hospitals, pharmacies and other providers. The other 48,000 beneficiaries are in "fee for service," where Medicaid is responsible for enrolling providers, setting payment rates, and processing claims.

Monthly Averages of Participating Providers

	FY 2003	FY 2004	FY 2005
Physicians	1,693	1,742	1,768
Pharmacies	181	181	191
Nurse practitioners	26	34	44
Dentists	19	20	23
Medical equipment & supplies	51	53	62
Transportation (excluding amb.)	146	152	182
Lab & X-ray providers	439	400	380

Note: "Participating" providers have billed Medicaid at least once during a one-month period.

■ **Rising participation rates.** A key measure of beneficiary access to care is the number of providers that serve Medicaid fee-for-service beneficiaries in a typical month. The table shows the provider types for which the participation rate is a good measure of access. (This rate is not as useful for hospitals, nursing facilities and other large providers that almost always serve some Medicaid beneficiaries each month.) MAA is pleased to report that participation rates have been rising for almost all provider types in the table.

■ **Increased electronic billing.** In FY 2005, MAA processed 7.0 million claims. The proportion of claims submitted electronically rose to 89% in FY 2005 from 77% the year before. The District's claims processing contractor turns around electronic claims within two days of receipt. Paper claims are keyed within an average of four days of receipt (a 19% improvement over FY 2004) and processed within two days after that. Providers are paid twice a month, in contrast to other Medicaid programs in this region that pay monthly. About 75% of payments are made by electronic funds transfer (EFT), up from 62% in FY 2004. EFT is significantly less costly for Medicaid than cutting paper checks.

■ **Increased communication with providers.** In FY 2005, MAA's claims processing contractor, ACS Government Healthcare Solutions, handled 84,899 phone calls from providers with an average answer time under 30 seconds. In addition, MAA and ACS increased their provider education efforts, which include quarterly newsletters, brochures on reducing billing errors and other topics, and over 300 face-to-face meetings with providers, in either individual or group sessions.

Medicaid's Economic Impact on the District of Columbia

Though Medicaid exists to improve the health of District residents, it's also important to the health of the D.C. economy.

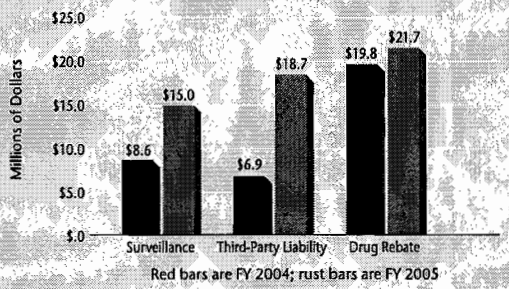
- First and foremost, providing health care to one-quarter of the D.C. population is essential to maintaining a healthy, productive D.C. workforce.
- 92% of the $1.22 billion that Medicaid spent on health care in FY 2004 was paid to D.C. providers. Of the remainder, 6% went to Maryland, 1% to Virginia and 0.5% to other states.
- Medicaid is the single largest source of federal funding to the D.C. government, bringing in about $900 million a year. Medicaid is cost-shared 30/70 between the two levels of government, so every D.C. Medicaid dollar is matched by $2.33 from the federal government.

Spending Dollars Wisely

Medicaid is the single largest spender in the D.C. government, with annual expenditures exceeding those of the K-12 public schools. Like all prudent purchasers, Medicaid seeks value for money—in this case, maximum health for the health care dollar. As a $1.26 billion program, Medicaid also inevitably attracts some providers intent on defrauding or abusing the program. This section describes initiatives related to value purchasing and program integrity.

■ **Fraud, waste and abuse recoveries rise 74%.** In FY 2005 MAA recovered $15.0 million as a result of efforts to protect against waste, fraud and abuse. Recoveries increased 74% over FY 2004. The surveillance and utilization unit and the investigations and compliance unit investigate possible overpayments to providers. These can reflect unintentional billing errors or conscious efforts to abuse or defraud the program. In FY 2005, for example, a physician, a dentist and a transportation provider were convicted of fraud. Five other cases are pending.

Across-the-Board Increases in Recoveries



Red bars are FY 2004; rust bars are FY 2005

■ **Third-party liability recoveries.** TPL recoveries were $18.7 million in FY 2005, more than double the previous year. Medicaid is the insurer of last resort, and the TPL unit recovers funds from other parties when they are liable for payments originally made by Medicaid. Third-party liability may exist when a beneficiary also has coverage from a commercial insurer, when a court holds a negligent driver financially responsible for injuring a Medicaid beneficiary, or when a deceased beneficiary's estate can pay for some of the care funded by Medicaid. In FY 2005, the TPL unit increased its efforts to recover money from third parties that were liable for care provided by Medicaid managed care plans. This effort paid off with a big increase in recoveries.

■ **Focus on cost avoidance.** Although TPL and fraud protection efforts bring in easily quantifiable recovery dollars, it is better practice to avoid the expenditures in the first place. In FY 2005, Medicaid tightened computer edits on the 250 most expensive physician services and on durable medical equipment, prosthetics, orthotics and supplies. Similar "cost avoidance" efforts in the future may well result in less need to recover dollars after the fact.

■ **Medicaid enrollees identification initiative.** In FY 2005, MAA implemented a new cost avoidance strategy to identify more Medicaid-eligible residents that are currently receiving public assistance paid by the District instead of through federal matching funds in the Medicaid program. MAA began conducting data matches to identify Medicaid-eligible students enrolled in the District's public schools, eligible recipients being assisted by the Department of Mental Health, and other eligibility shown on provider records.

■ **$21.7 million in revenue from drug rebates.** Drug rebate revenue rose 9.6% between FY 2004 and FY 2005. Rebates come from drug manufacturers under a federal law that requires that manufacturers always give Medicaid their best prices. To receive the rebates, Medicaid must meticulously track dosages on 1.2 million prescriptions a year and then defend the data to drug manufacturers. In a comparison of eight Medicaid programs, D.C. had the highest success ratio of rebates received to rebates invoiced.

■ **Plan to hire transportation broker.** In FY 2006, Medicaid will improve the organization of non-emergency transportation services, such as the wheelchair vans that take beneficiaries to medical appointments. Instead of dealing individually with each transportation provider, we will contract with a transportation broker to coordinate requests for service, supervise the service provided by individual transportation providers, and monitor providers for fraud. About 3,700 beneficiaries a month currently use these services.

■ **Plan to improve drug purchasing.** In FY 2006, we will take two steps to control drug expenditures while maintaining access to cost-effective drugs. First, we will follow the successful efforts of other Medicaid programs in using Maximum Allowable Cost (MAC) pricing for certain generic drugs. MAC prices more closely reflect actual marketplace prices than do the widely published Average Wholesale Prices or Federal Upper Limit prices. Second, we will implement a Preferred Drug List, which will increase competition among drug manufacturers for Medicaid's business.

■ **Plan to assess payment levels for health care.** In FY 2006, Medicaid will undertake a review of its payment levels for a wide range of services. Changes to payment levels are possible if such changes would make Medicaid a more effective purchaser of care.

■ **Payment Error Rate Measurement (PERM).** The District was awarded a federal grant to pilot test the PERM process that will be implemented nationwide in FY 2006. The pilot, which began in October 2004 and ended in September 2005, was designed to measure the accuracy of Medicaid payments using a sophisticated sampling methodology. It covered both the fee-for-service and managed care components and was designed to identify both payments that were too high and those that were too low. The pilot will yield important information to the District and will help the federal government develop final PERM regulations that are fair and accurate to Medicaid programs and providers.

■ **Partnerships with the private sector.** MAA uses a stringent competitive bidding process to hire experienced contractors to help it run the complex Medicaid program. In FY 2006, MAA expects to issue requests for proposals for four major contracts: the fiscal agent, which processes claims through the Medicaid Management Information System (MMIS); the pharmacy benefit manager, which administers the pharmacy claims payment system; the transportation broker described earlier in this section; and a decision support system (DSS). The DSS will be a new contract that will give Medicaid policy managers greatly increased access to the data necessary to manage the program.

How One Fraud Scheme Was Stopped

One individual probably thought he could make some easy money presenting fabricated prescriptions to pharmacies. He posed as a "runner" for a personal care home and said the prescriptions were for Medicaid beneficiaries. At one pharmacy, for example, he submitted 1,695 prescriptions in just three months. He used the name of a real physician (who was not involved) but a fictitious physician identification number. He was arrested for narcotics violations, pled guilty to a $1.4 million fraud scheme and was jailed.

And there the matter would have ended, except that federal and District investigators turned to the pharmacies that filled the fraudulent prescriptions. On July 28, the government announced that Chronimed Inc. had agreed to pay $475,000 to settle allegations that it submitted false claims. Investigations of other pharmacies are under way.[10]

Working for Medicaid Beneficiaries

A total of 121 people work for the Medical Assistance Administration, the lead agency for administering the D.C. Medicaid program. In this section we describe some of the work they do.

■ **Suprenia Robinson**, a program analyst in the Program Operations area, has worked with the Medicaid program for 15 years, first as a staff member for the claims processing contractor and then, since 2001, for MAA. "One of the reasons I've stayed with Medicaid so long," explains Suprenia, "is because I can help people. It's rewarding to know that during the course of my day, I've been able to help someone."

On average, Suprenia fields 60 to 80 calls each day from providers or social workers seeking authorizations for non-emergency transportation for disabled Medicaid beneficiaries. She also trains providers on how to submit claims accurately, resolves billing discrepancies, and processes provider appeals.

■ **Jeff Anderson** is a former U.S. Navy Search and Rescue aircrewman who joined MAA earlier this year as a public health analyst. "I wanted to continue to work in an environment where I could help people," says Jeff. "I certainly enjoy working with people who want help, but it makes me feel better working with those who need help."

Jeff largely focuses on implementing the District's home and community-based services (HCBS) program in support of the Real Choice Systems Change (RCSC) grant that MAA received from the federal government in September 2002. Jeff coordinates consensus-building meetings and works with a diverse group of stakeholders, including representatives of MAA's Office on Disabilities and Aging, the RCSC advisory committee, various subcommittees, beneficiaries, and providers to determine how best to serve the community.

■ **Elisa Fauntleroy** joined the Office of Managed Care as a program analyst and is one of seven staff members who works to ensure that the 93,000 Medicaid managed care beneficiaries have access to quality health care. Part of her job is to monitor MAA's contract with the District's four managed care plans.

Elisa also serves as the "go to" person when eligibility questions arise for managed care beneficiaries. She serves as a liaison with the D.C. Income Maintenance Administration (IMA), which determines Medicaid eligibility, and with the contractor that coordinates managed care enrollment. "When people have questions, I'm the person they can always reach," Elisa explains. "Nine times out of 9½ times, I can get it done. Resolving most recipient eligibility issues usually means a quick call to IMA, and we're able to resolve the issue usually within 24 hours. All you have to do is get on the phone and talk to the right person."

■ **Gwendolyn Bell**, a physician assistant, plays a key role in spearheading MAA's quality management and in managing the prior authorization review process. Daily, Gwen fields more than 60 calls from providers requesting authorization for unusual, expensive or medically complex services. She monitors the integrity of the medical records review process and helps to develop state plan amendments, among her many efforts to promote better quality and access to health care. After Hurricane Katrina, Gwen was one of several MAA employees who provided care to evacuees housed at the D.C. Armory. She cancelled her vacation days to do it.

While the pace of Gwen's job is fast, ultimately it's the satisfaction of helping someone that makes it worthwhile. As she explains, "They're so appreciative once you've helped them resolve the issue, and that makes all the difference. Hearing a 'thank you' for solving their problems is what keeps me going."

■ **Diallo "Abe" Bennett** joined MAA in 2001 as chief of investigations to reduce fraud and protect the integrity of public funds administered by Medicaid. With 20 years as a detective in the New York Police Department, as the former chief of the fraud unit in the Georgia Medicaid program, and with a wealth of experience in security management at private firms, Abe came very well prepared.

"I love my job and I feel I can help people—people who are probably in the least fortunate position," explains Abe. His unit's main goal is to "pay the right amount to a legitimate provider for covered, reasonable, and necessary services provided to eligible recipients."

Though Abe's job involves knowing about criminals, it also requires him to understand the intricacies of health care coding and billing, since this is how fraud gets perpetrated. He also believes in the importance of prevention, educating providers on how to avoid errors.

In August 2005, the U.S. Attorney for D.C. commended Abe for his contribution to the successful resolution of a case that recovered $475,000. (See page 19.) The federal Centers for Disease Control and Prevention has also asked Abe to help write a policy manual on combating fraud in the Vaccines for Children Program.

■ **Milka Shephard**, a program specialist, joined Medicaid 16 years ago, and now reports to the Medicaid director. Her job is to make sure that requests for information from beneficiaries, other D.C. agencies, the federal government, providers and community-based organizations are handled promptly through either the director or one of his staff. As Milka puts it, "I want things done to the best of my abilities in a timely manner."

Milka often uses her bilingual skills to field inquiries from Spanish-speaking beneficiaries. "While we can refer non-English speaking beneficiaries to Language Line services for assistance when they call, if they speak Spanish, it's easier for me to find out what they need and help them," she says. "I always put myself in their shoes. What if it was me? I'll do whatever it takes to help someone because I love what I do."

Understanding Medicaid Finances

Medicaid is a highly complex program that funds a very wide range of health care services in accordance with numerous federal and District statutory, regulatory and policy provisions. In this section we explain the D.C. Medicaid budget and some of the factors that drive it.

MEDICAID SPENDING IN CONTEXT

In FY 2005, spending for care was $1.26 billion (preliminary data), a 3.4% increase from FY 2004. The increase reflects a 2.1% increase in average monthly enrollment and a 1.3% increase in average monthly spending per enrollee. By contrast, the average cost of an employment-based family insurance plan rose 9.2% from 2004 to 2005, according to the September/October 2005 issue of *Health Affairs*.

The federal government pays 70% of the total and District taxpayers pay 30%.

The table on this page presents an overview of spending by responsibility center for FY 2004 through FY 2006, while the table on page 23 offers insight into detailed spending patterns in FY 2004. In a typical month, for example, there were 7,609 beneficiaries who received at least one physician service during the month. For these 7,609 recipients, Medicaid spent $187 per person per month, on average.

In reviewing the detailed spending data, three points should be kept in mind. With very minor exceptions, all Medicaid spending for managed care enrollees is shown in the "insurance premiums" category. Second, care provided under waiver programs (for example, most personal care) is shown under the "waiver" category. Third, spending totals under other categories (especially physician and hospital) include spending both on beneficiaries for whom Medicaid is the primary payer, and on beneficiaries for whom Medicaid is the secondary payer behind Medicare.

The D.C. Medicaid Budget

Responsibility Center	Actual FY 2004	Preliminary FY 2005	Budgeted FY 2006
Disproportionate Share Hospital Payments (6020)	$ 40,566,000	$ 40,188,012	$ 41,086,606
Day Treatment (6030)	27,291,000	26,530,713	27,326,634
Inpatient Hospital (6050)	249,270,000	272,787,923	280,971,561
Outpatient Hospital (6060)	25,007,000	19,276,729	20,047,798
Insurance Premiums (6070)	289,754,000	305,689,430	317,917,007
Nursing Facilities (6140, 6080)	182,048,000	176,977,991	186,769,173
Intermediate Care Facilities for the Mentally Retarded (6110)	77,317,000	78,405,445	81,613,033
Physician Services (6120)	17,053,000	18,389,101	19,124,665
Residential Treatment (6130)	13,089,000	14,033,602	14,594,946
Vendor Payments (6150)	162,754,000	169,731,140	183,512,970
Cost Settlement (6160)	11,300,000	22,977,417	22,977,417
St. Elizabeth's Hospital (6170)	34,559,000	25,956,923	42,381,548
D.C. Public Schools (6180)	19,636,000	19,375,879	22,258,552
D.C. Child & Family Services (6190)	48,736,000	41,960,556	38,322,831
Waivers	22,655,000	30,143,548	38,293,010
Subtotal Payments for Care	**$ 1,221,035,000**	**$ 1,262,424,409**	**$ 1,337,197,753**
MAA Administration (6010)	30,704,000	36,737,155	38,904,904
TOTAL	**$ 1,251,739,000**	**$ 1,299,161,564**	**$ 1,376,102,657**
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	$ 732	$ 741	$ 769

Notes

1. The fiscal year runs from October 1 through September 30. Expenses are tallied on an accrual basis.

2. FY 2005 numbers are preliminary data as of September 2005.

3. FY 2006 enrollment figure assumes a continuation of the growth rate seen between FY 2004 and FY 2005. It is not an official MAA projection.

4. "MAA administration" excludes other costs of administering Medicaid, such as the cost of eligibility determination borne by the Income Maintenance Administration.

Behind the Numbers: Detail of Medicaid Spending, FY 2004

Responsibility Center	Actual FY 2004	Average Spending per Month	Average Recipients per Month	Average Spending per Recipient per Month
Disproportionate Share Hospital Payments (6020) *Supplementary payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients*	$ 40,566,000	$ 3,380,500	N/A	$ N/A
Day Treatment (6030) *Day treatment programs for people with mental illness*	$ 27,291,000	$ 2,274,250	1,241	$ 1,833
Inpatient Hospital (6050) *Payments to acute-care hospitals for inpatient care*	$ 249,270,000	$ 20,772,500	1,953	$ 10,636
Outpatient Hospital (6060) *Payments to acute-care hospitals for outpatient care*	$ 25,007,000	$ 2,083,917	6,763	$ 308
Insurance Premiums (6070) *Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.*	$ 289,754,000	$ 24,146,167	100,718	$ 240
Nursing Facilities (6140, 6080)	$ 182,048,000	$ 15,170,667	2,900	$ 5,232
Intermediate Care Facilities for the Mentally Retarded (6110)	$ 77,317,000	$ 6,443,083	656	$ 9,828
Physician Services (6120)	$ 17,053,000	$ 1,421,083	7,609	$ 187
Residential Treatment (6130) *Non-hospital inpatient care for people with mental illness.*	$ 13,089,000	$ 1,090,750	124	$ 8,779
Vendor Payments (6150)	$ 162,754,000	$ 13,562,833		
Pharmacy (retail)	101,071,000	8,422,622	19,058	442
Home health care	22,357,580	1,863,132	1,153	1,616
Medical transportation (e.g., wheelchair vans)	18,769,674	1,564,140	4,016	389
Federally qualified health centers	2,395,628	199,636	1,020	196
Durable medical equipment	9,680,493	806,708	2,469	327
Personal care (assistance with activities of daily living)	597,000	49,750	63	786
Mental health clinics	4,801,000	400,083	N/A	N/A
Lab & x-ray (facilities separate from hospitals and clinics)	3,853,000	321,083	3,967	81
Private clinics	10,223,341	851,945	855	996
Hospice	1,427,154	118,929	29	4,073
Dental	766,000	63,833	335	190
Other vendor payments (e.g., optometrist, rehabilitation)	6,591,664	549,305	N/A	N/A
Drug rebates	(19,780,000)	(1,648,333)	19,058	(86)
Cost Settlement (6160) *Net impact of retroactive payment adjustments due to cost report settlements for providers paid based on their costs.*	$ 11,300,000	$ 941,667	N/A	N/A
D.C. Mental Health & St. Elizabeth's Hospital	$ 34,559,000	$ 2,879,917	3,257	$ 884
D.C. Public Schools (6180) *Payment to DCPS for health services provided to students enrolled in Medicaid, typically for students with disabilities.*	$ 19,636,000	$ 1,636,333	2,301	$ 711
D.C. Child & Family Services (6190) *Payment to CFS for health services provided to clients enrolled in Medicaid, typically for managing care for people with disabilities.*	$ 48,736,000	$ 4,061,333	2,676	$ 1,518
Waivers *Innovative programs operated under waivers from the federal government.*	$ 22,655,000	$ 1,887,917	1,473	$ 1,282
TOTAL SPENDING FOR CARE	$1,221,035,000			

MEDICAID ADMINISTRATION

The Medical Assistance Administration (MAA) is the lead agency for administering the Medicaid program. MAA spending on Medicaid administration in FY 2005 is projected to be $36.7 million. This figure includes both the salaries of Medicaid staff and payments to contractors, such as those that process Medicaid claims, respond to provider inquiries and perform related functions. The number excludes the costs of other D.C. agencies that help administer Medicaid, such as the Income Maintenance Administration, which determines eligibility. Even when all administration costs are totaled, however, Medicaid is still much less expensive to administer than commercial insurance, where the cost of administration averages 13.6% of spending, according to CMS.[11]

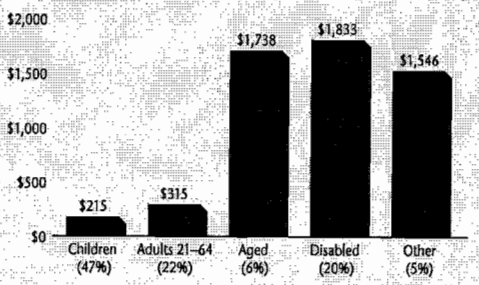
PATTERNS OF SPENDING

Medicaid spending is highly correlated with the type of eligibility a beneficiary has. On average, spending is relatively low for children and for non-disabled adults aged 21-64 (most often, the child's mother). Their health needs are similar to those of a commercially insured population, except with more emphasis on obstetrics and pediatrics. The 96,000 people in these two categories account for 69% of Medicaid enrollment but just 24% of Medicaid spending. They are primarily enrolled in Medicaid managed care plans.

On the other hand, spending is relatively high for people aged 65 or more and for people with disabilities. For some of these beneficiaries, Medicare covers their acute care costs, such as physician care and hospital stays. For dual eligibles, Medicaid usually pays their Medicare cost-sharing obligations (deductible, coinsurance, premiums) and these costs may be significant. And for some people in these groups, Medicaid is their only source of acute care coverage.

Most important, beneficiaries in these groups rely on Medicaid to cover the cost of long-term care, such as long stays in nursing facilities and home and community-based services that enable the beneficiary to avoid institutionalization. Overall, the aged, disabled and "other" categories (which mostly include people in waiver programs) represent 31% of Medicaid enrollment but 76% of Medicaid spending.

Spending per Month by Eligibility Category



For example, children represent 47% of total enrollment.

Notes

1 Jon Gabel, Gary Claxton, Isadora Gil and others, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.

2 Sara R. Collins, Karen Davis, Michelle M. Doty, and Alice Ho, *Wages, Health Benefits, and Workers' Health,* Issue Brief No. 788 (New York: The Commonwealth Fund, October 2004).

3 Estimates were made by ACS Government Healthcare Solutions based on Medicare and Medicaid administrative data and the 2002–03 Current Population Survey as analyzed by the Kaiser Family Foundation. (See www.statehealthfacts.org.)

4 Kaiser Commission on Medicaid and the Uninsured, www.statehealthfacts.org. The figures are for 2002–03.

5 FY 2005 spending totals are projections as of September 2005. Spending is accounted for on accrual basis, so final numbers may differ from the projections shown here.

6 Jon Gabel, Gary Claxton, Isadora Gil and others, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.

7 Stephen Heffler, Sheila Smith, Sean Keehan and others, "U.S. Health Spending Projections for 2004–2014," *Health Affairs,* Web Exclusives (February 23, 2005), p. W4-78; Stephen Heffler, Sheila Smith, Sean Keehan and others, "Health Spending Projections Through 2013," *Health Affairs,* Web Exclusives (February 11, 2004), p. W5-85.

8 For further information on HEDIS measures and NCQA accreditation, see www.ncqa.org.

9 U.S. General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations,* GAO/HEHS-00-149 (Washington, DC: GAO, 2000), p. 10.

10 U.S. Attorney for the District of Columbia, "United States Reaches $475,000 Settlement with a National Pharmacy Corporation to Settle Allegations that False Claims Were Submitted to Medicaid for Illegally Diverted Prescription Medications," news release, August 4, 2005.

11 Cynthia Smith, Cathy Cowan, Art Sensenig and others, "Health Spending Growth Slows in 2003," *Health Affairs* 24:1 (January/February 2005), p. 192.

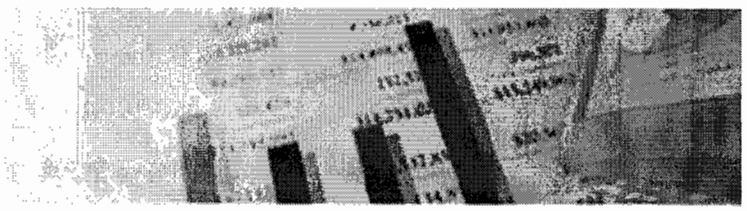
For More Information

Information Need	Resource	Contact Information
Am I eligible for Medicaid? What do I do if my Medicaid card expires?	D.C. Department of Human Services, Income Maintenance Administration	202-727-5355 www.dhs.dc.gov
I can no longer live at home by myself. What are my options?	D.C. Resource Center for Aging and Persons with Disabilities	202-204-3540 info@dcresourcecenter.com 2311 Martin Luther King Ave. SE Washington, D.C. 20020
I have a question about my Medicaid benefits.	**Managed care:** Call your health plan. **Fee-for-service:** D.C. Medical Assistance Administration	**AMERIGROUP:** 800-600-4441 **D.C. Chartered Health Plan:** 800-408-7511 **Health Right:** 877-284-0282 **HSCSN:** 866-937-4549 **Fee-for-service:** 202-442-5988
I have a complaint about my Medicaid managed care plan.	Managed care complaint hotline	800-788-0342
How do I change from one managed care plan to another?	Managed care enrollment broker	202-639-4030
I want to report possible waste, fraud or abuse in Medicaid.	D.C. Medicaid Fraud Hotline	877-632-2873
I'm a health care provider. How do I enroll in Medicaid? How do I check whether my patient is eligible for Medicaid? What if I have a question about a claim I submitted?	ACS Government Healthcare Solutions (fiscal agent for D.C. Medicaid)	**Provider enrollment:** 202-906-8318 **Eligibility verification:** 202-610-1847 **Other inquiries:** 202-906-8319
I'm a health care provider. How do I obtain prior authorization for services?	**Pharmacy:** First Health Services **Other:** D.C. Medical Assistance Administration	**Pharmacy:** 804-527-5757 **Other:** 202-442-9115
How do I get a job at MAA?	D.C. Office of Personnel	202-671-1300
I'm a policy analyst or journalist with questions about Medicaid policy or budget.	Office of the Medicaid Director	202-442-5988
All other inquiries.	D.C. Medical Assistance Administration	202-442-5988 Room 5135 825 North Capitol St., NE Washington, D.C. 20002 www.doh.dc.gov

★ ★ ★
Government of the
District of Columbia
Anthony A. Williams, Mayor

TAB D

Center on Budget and Policy Priorities



Revised February 17, 2006

NEW REQUIREMENT FOR BIRTH CERTIFICATES OR PASSPORTS COULD THREATEN MEDICAID COVERAGE FOR VULNERABLE BENEFICIARIES: A STATE-BY-STATE ANALYSIS

By Leighton Ku and Matt Broaddus

The Deficit Reduction Act, which was signed by the President on February 8th, contains a provision that would require all citizens applying for Medicaid or renewing their coverage to produce a passport or birth certificate to prove they are U.S. citizens. There would be no exceptions for any Medicaid applicants or beneficiaries, not even individuals with severe physical or mental impairments such as Alzheimer's disease.

This new requirement, which a recent study by the Inspector General of the Department of Health and Human Services shows to be unnecessary, would almost certainly create significant enrollment barriers for millions of low-income citizens who meet all Medicaid eligibility requirements. It also would increase Medicaid administrative costs. (For a discussion of these issues, see Leighton Ku and Donna Cohen Ross, "New Medicaid Requirement Is Unnecessary and Could Impede Citizens' Coverage and Policy Priorities," revised January 4, 2006.)

This analysis provides estimates of the number of Medicaid beneficiaries in each state who would be required to submit a passport or birth certificate between July 2006 (when the new requirement would take effect) and June 2007, and who would be cut off Medicaid if they are unable to do so.

- Analyses of Census data and Medicaid administrative data indicate that about 49 million native-born U.S. citizens and two million naturalized citizens were enrolled in Medicaid over the course of the year in 2003. (Fewer than 4 million legal immigrants also participated.) Thus, about 49 million people would be required to submit birth certificates or passports or lose their Medicaid coverage. (The two million beneficiaries who are naturalized citizens would be allowed to submit naturalization documents.)

- Once they took effect on July 1, 2006, these new requirements would apply to *all* applications or redeterminations of eligibility that occurred after that date, without any exceptions even for people who are extremely old or have severe physical or mental impairments, such as Alzheimer's disease. In the following six to twelve months after July 1, 2006, states would have to check citizenship documents for more than 50 million beneficiaries. This would constitute a significant new administrative burden for state and local agencies.

The New Documentation Requirement

Under Section 6037 of the conference agreement on the budget reconciliation bill, states would have to require all current and new Medicaid beneficiaries applying as citizens to provide proof of their citizenship. The primary forms of documentation acceptable would be either a passport or a birth certificate presented in conjunction with proof of identity such as a driver's license. For people who are naturalized citizens, naturalization papers also would be accepted. (The Secretary of HHS would be permitted to specify other acceptable forms of documentation, but the only forms of documentation the Secretary could allow would be forms of documentation that are issued solely to citizens

and for which proof of citizenship must be provided. This essentially means that native-born citizens would have to produce birth certificates or passports.)

The documentation requirements would take effect July 1, 2006 and would be required when people apply for benefits or, for current beneficiaries, at recertification. Since certification periods typically are six months, most of this burden will fall between July and December 2006, although some certification periods last 12 months.

- In 16 states, the number of Medicaid beneficiaries who would be required to submit this new paperwork would exceed one million.

- If as little as two percent of Medicaid beneficiaries cannot readily come up with a birth certificate or passport, one million low-income Americans could lose Medicaid coverage and become uninsured or be delayed in obtaining coverage. The percentage of U.S. citizen beneficiaries who are unable to produce readily a birth certificate or passport may well be much larger than that.

The Medicaid program already has extensive requirements to check the immigration status of *non*-citizens who apply for Medicaid. Non-citizen applicants must provide documentation of their immigration status, and state officials check computerized federal records to verify that status. The new requirement would apply only to people applying for Medicaid as U.S. citizens.

Most states currently allow citizen applicants to self-attest, under penalty of perjury, that they are citizens. Most states then ask for proof of citizenship if they have any reason to question the applicant's truthfulness. A comprehensive study issued by the HHS Office of the Inspector General (OIG) last year found no substantial evidence that illegal immigrants were claiming to be citizens and successfully enrolling in Medicaid, and OIG did *not* recommend requiring all applicants to provide documentation. [1] In the absence of evidence that there is a problem in Medicaid, there is no sound reason to create significant new barriers for citizens and increased administrative costs for states.

The new requirements would be imposed on all citizens who apply for or are already receiving Medicaid. There would be no exceptions, regardless of an individual's physical or mental condition. People currently enrolled in Medicaid would lose coverage if they could not provide such documents when they were recertified.

Large numbers of eligible people could lose coverage because they do not have a birth certificate or passport available at the time they apply or reapply for Medicaid. Low-income individuals on Medicaid usually do not travel abroad and often lack passports. Birth certificates may have been lost over the years in which people move from one home to another; in some cases, as explained below, individuals may have been born outside a hospital and no birth certificate may have been issued. Those who may be harmed include:

- People who have a sudden emergency and need Medicaid coverage immediately but cannot get these documents quickly (some states take a month or longer to provide a duplicate birth certificate when one is requested);

- Those who are homeless, mentally ill, or suffering from senility or a disease such as Alzheimer's, and who may not be able to secure a birth certificate (or even to recall where they were born);

- People who are in nursing homes or are severely disabled, and would have difficulty getting access to their birth certificates; and

- Those affected by disasters like Hurricanes Katrina or Wilma who have lost

most of their possessions and records.

Citizens who have already demonstrated their citizenship for other federal programs, such as Supplemental Security Income or Medicare, would still be required to produce documentation for Medicaid or lose coverage.[2]

In some cases, people may have never been issued a birth certificate because they were born at home and their birth was not officially registered. A particular problem exists for a large number of elderly African Americans because they were born in a time when racial discrimination in hospital admissions, especially in the South, as well as poverty, kept their mothers from giving birth at a hospital. One study estimated that about one in five African Americans born in the 1939-40 period lack a birth certificate because of these problems.[3] Thus, this new provision would exacerbate a historical legacy of discrimination and could lead to a large number of elderly African Americans losing access to health care.

New State Estimates

To understand the potential impact of this legislation, we used Census data and administrative data to estimate the number of citizens who are covered by Medicaid and thus would be required to prove their citizenship.

We used data from the Census Bureau's March 2003, 2004 and 2005 Current Population Surveys to compute the percentage of Medicaid beneficiaries in each state who are native or naturalized citizens and those who are non-citizen beneficiaries. We applied these percentages to administrative data (from HHS' Medicaid Statistical Information System) on the number of people enrolled in Medicaid in each state at any point during fiscal year 2003. These estimates are presented in the table below.

Estimated Number of Citizens Who Are Enrolled in Medicaid in Each State Over the Course of a Year And Thus Will Be Required to Produce These Documents

United States	**51,285,000**		Missouri	1,147,000
Alabama	882,000		Montana	110,000
Alaska	122,000		Nebraska	260,000
Arizona	1,133,000		Nevada	227,000
Arkansas	673,000		New Hampshire	126,000
California	8,192,000		New Jersey	882,000
Colorado	446,000		New Mexico	479,000
Connecticut	479,000		New York	3,993,000
Delaware	153,000		North Carolina	1,420,000
Dist. Columbia	150,000		North Dakota	75,000
Florida	2,590,000		Ohio	1,911,000
Georgia	1,611,000		Oklahoma	654,000
Hawaii	201,000		Oregon	607,000
Idaho	203,000		Pennsylvania	1,746,000
Illinois	2,091,000		Rhode Island	188,000
Indiana	927,000		South Carolina	984,000
Iowa	370,000		South Dakota	118,000
Kansas	316,000		Tennessee	1,627,000
Kentucky	802,000		Texas	3,430,000
Louisiana	1,054,000		Utah	266,000
Maine	374,000		Vermont	157,000
Maryland	798,000		Virginia	727,000
Massachusetts	1,055,000		Washington	1,085,000
Michigan	1,531,000		West Virginia	365,000

Minnesota	678,000		Wisconsin	885,000
Mississippi	729,000		Wyoming	77,000
Based on Census and Medicaid administrative data for 2003.				

Overall, these data indicate that 51 million of the 55 million Medicaid beneficiaries in 2003 are U.S. citizens and thus would be subject to the new requirement. In every state, the vast majority of Medicaid beneficiaries are citizens.

In 16 states — Arizona, California, Florida, Georgia, Illinois, Louisiana, Massachusetts, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas and Washington — more than one million Medicaid beneficiaries would be required to submit new paperwork to receive or stay on Medicaid.

Data from a national survey has led to the conclusion that about three to five million citizens enrolled in Medicaid do not have a birth certificate or passport readily available and could have their Medicaid coverage jeopardized by this new requirement.[4] This includes about 1.4 to 2.9 million children and 1.7 million adults. African Americans, senior citizens and those living in rural areas are more likely to lack birth certificates or passports and would be more strongly affected. We are unable to estimate the number of citizens who lack a birth certificate or passport on a state-y-state basis.

Administrative Burdens

Not only would this cause problems for Medicaid beneficiaries, but it would create new administrative burdens and costs for the state and local agencies that operate Medicaid. These agencies would be required to notify applicants of the new requirements, check their documents, keep records that the documents were submitted, delay enrollment if people cannot locate the documents, and in some cases, try to help people locate the documents. The Medicaid director for Connecticut has observed that requiring documentation "would be an enormous administrative burden." Wisconsin's Medicaid director has said that the proposal "would have a material and significant effect on enrollment."[5]

In addition to slowing enrollment processing and increasing administrative costs, the new requirement could have other effects on states. Medicaid has a "quality control" system designed to measure the accuracy of state performance in operating the Medicaid program, and HHS currently is beefing up that system. Under the quality control system, states that do not terminate all beneficiaries who are unable to produce birth certificates or passports could be determined to have substantial levels of Medicaid errors and could face federal fiscal sanctions and penalties.

End Notes:

[1] HHS Office of the Inspector General, "Self-Declaration of U.S. Citizenship Requirements for Medicaid," July 2005.

[2] One provision appears to offer an exemption of documentation requirements for people already on SSI or Medicare, but this provision applies only to non-citizens.

[3] S. Shapiro, "Development of Birth Registration and Birth Certificates in the United States," Population Studies, 4:86-111, 1950. Cited by I. Rosenwaike and M. Hill, "The Accuracy of Age Reporting Among Elderly African-Americans: Evidence of a Birth Registration Effect," Population Aging Research Center, Univ. of Pennsylvania, Working Paper, July 1995.

[4] Leighton Ku, Donna Cohen Ross and Matt Broaddus, "Survey Indicates that the Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens," Center on Budget and Policy Priorities, revised Feb. 17, 2006.

[5] John Reichard, "Critics Say New Documentation Rules for Medicaid Would Reduce Enrollment," CQ HealthBeat, Nov. 8, 2005.

Click here to join the Center's e-mail notification list.
To ask questions, or send comments, write to bazie@cbpp.org
Center on Budget and Policy Priorities
820 First Street, NE, Suite 510
Washington, DC 20002
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Fax: (202) 408-1056

Center on Budget and Policy Priorities

TAB E

Government of the District of Columbia
Department of Human Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you can **APPLY** or be **RECERTIFIED** for one or more of the following assistance programs;

- **Medical Assistance**
- **Food Stamps**
- **Financial Assistance/TANF**

COMPLETING THIS APPLICATION

If you need help completing this application, a friend, relative or other individual may help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and the date next to the change. If more than 6 people are living in your home and you need more space to list everyone and complete information on any of the pages, tell the agency you need extra pages. If you want Medical Assistance and you are under 21 years of age, under certain circumstances your parent or legal guardian may need to sign the application.

If you are currently receiving benefits and are applying for **RECERTIFICATION** of Food Stamps or Financial Assistance/TANF this application form will be used for recertification of benefits. A different form will be provided if you are requesting recertification for Medical Assistance only.

This application contains information about the programs available at your local service center office plus other very important information you should know, including your rights and responsibilities. **READ THIS APPLICATION CAREFULLY AND THOROUGHLY.**

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you refuse to give needed information, your eligibility for assistance may be denied. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be prosecuted for fraud.

VERIFICATION OF INFORMATION

The information that you give may be matched against Federal, State, and local records including the Department of Employment Services and the Department of Motor Vehicles, and the Income and Eligibility Verification System (IEVS) to determine if it is correct, accurate, and truthful. As a condition of eligibility you must apply for and cooperate with the agency in obtaining a social security number for yourself and the persons for whom you are applying for assistance.

In addition, your Social Security Number will be used to verify your identity, prevent receipt of duplicated benefits, and make required program changes. This system uses your Social Security Number to verify wages and salary, unemployment benefits, and unearned income by using records from the Internal Revenue Service and the Social Security Administration.

Any difference between the information you give and these records will be investigated and may require a home visit. Information from these records may affect your eligibility and benefit amount.

INSTRUCTIONS FOR COMPLETING THIS APPLICATION

1. When completing this application be sure to **PRINT ALL YOUR ANSWERS.**

2. Do not write in the shaded areas. **These areas are for agency use only.**

3. Answer the questions in **PART A: GENERAL INFORMATION** for <u>everyone who lives in your home</u>, even if you are not applying for that person.

4. Answer the questions in **PART B: RESOURCES** and **PART C: INCOME** for <u>everyone for whom you are applying</u>. In addition, if applying for **Medical Assistance** or **Financial Assistance/TANF**, also provide resource and income information for the following persons:

   - **Medical Assistance:** Spouse and children under age 21 who live with a person for whom you are applying, parents who live with a child under age 21, and the spouse of a person in a nursing facility, state hospital, or community-based care facility. Provide the spouse's shelter bills to your worker.

   - **Financial Assistance/TANF:** Children age 19 or under, even if you <u>are not</u> applying for that child.

5. After completing PARTS A, B, and C, answer the questions in the sections indicated below.

   Medical Assistance.....**Part D** p. 8 - 9

   Food Stamps.....**Part E** p. 10 - 11

   Financial Assistance/TANF.....**Part D** p. 8 - 9
   Part E p. 10 - 11

6. All applicants must carefully read and complete **PART G: YOUR RIGHTS AND RESPONSIBILITIES.** **Be sure to complete and sign** the "Assignment of Rights to Medical Support" on page 13 if you are applying for Financial Assistance or Medical Assistance. **Be sure to provide the required signature(s) on the last page of this application.**

7. Read **VOTER REGISTRATION** on page 14 of this application.

8. **BE SURE TO SIGN AND DATE PAGE 15 OF THIS APPLICATION.**

Government of the District of Columbia
Department of Human Services
APPLICATION FOR BENEFITS

AGENCY USE ONLY				
Case Name	Case Number	Program	Worker Caseload	Date Received
Service Center	Date of Interview		Date of Disposition	
Programs: Approved		Denied		( ) Spanish Down

( ) **Initial Application** ( ) **Recertification** (Identify the program(s) from which you are applying for recertification in item number 1.)

1. I WISH TO APPLY FOR: ( ) **Medical Assistance** ( ) **Food Stamps** ( ) **Financial Assistance/TANF**

Applicant's Name: (Last) (First)	**Social Security Number:**	**Phone Number:** Home: Work::
Other Names Used: Maiden: **Aliases:**		
Residence Address (Include City, State and Zip Code):		
Mailing Address (If Different):		

A. Does anyone have an emergency medical need? **YES ( ) NO ( )** If YES, give name and explain_____

B. Is the applicant living in an Community Residential Facility, a State Hospital, a Nursing Home, or other institution? **YES ( ) NO ( )**
If YES, provide date entered: _____ If outside the District of Columbia, was placement made by a government agency? **YES ( ) NO ( )**

C. Is the applicant: SINGLE ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED ( ) If **SEPARATED** provide: Date of separation:_____
Spouse's Name_____ Spouse's Address_____

YES ( ) NO ( ) 2. Have you or anyone for whom you are applying ever applied for or received any benefits from the District of Columbia or another State, including TANF, Food Stamps, or any other assistance? If YES, provide the information in the box below.

Applicant's Name:	**Social Security Number:**	**Dates Received Assistance:**
Type of Benefits Applied For or Received:		
From What County, City or State:		

YES ( ) NO ( ) 3. If you are not registered to vote where you currently live, would you like to register to vote here today?

YES ( ) NO ( ) 4. Are you or anyone for whom you are applying either a convicted felon in flight to avoid capture or in violation of probation or parole?

YES ( ) NO ( ) 5. Have you or anyone for whom you are applying been convicted of a drug related felony after August 22, 1996?

YES ( ) NO ( ) 6. Do you and those for whom you are applying plan to remain in D.C.? If NO, please explain:

PART A: GENERAL INFORMATION (ALL APPLICANTS MUST COMPLETE THIS SECTION)

1. In the boxes provided below, list everyone living in your home, even if you are not applying for assistance for that person. (Race information is not required.)

Check (✓) YES ( ) NO ( ) Do you expect any change in who lives in your home, either this month or next month? If YES, explain:

Identify the type(s) of Program Assistance being requested for each person by placing the appropriate Program Code(s) in the box provided below labled "Program". Program Codes: M...Medical Assistance FS...Food Stamps T....TANF/Financial Assistance N....None

2. Relationship to Person Applying on Line #1-Self

Identify the relationship of each person to the person listed on Line #1.

Program						2. Relationship
Program	NAME (Self):				Client ID #:	SELF
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	
Program	NAME:				Client ID #:	
	Date of Birth:	Place of Birth:	Age:	Sex:	Race: Social Security #:	

YES ( ) NO ( ) 3. Is anyone for whom you are applying temporarily away from the home ? If **YES**, provide: Person(s) Name:__________
Expected Date of Return:__________

YES ( ) NO ( ) 4. Are you or anyone for whom you are applying pregnant? If **YES**, provide: Person(s) Name:__________
Expected Delivery Date:__________

Government of the District of Columbia
DEPARTMENT OF HUMAN SERVICES
INCOME MAINTENANCE ADMINISTRATION

CITIZEN/ALIENAGE DECLARATION

I certify under penalty of perjury, by signing my name below, that I am an adult U.S. citizen, U.S. national, or qualified alien. Also, I certify that the information on this form is true and that each member of the household who is applying for benefits listed below is a citizen or qualified alien. Please note that only information regarding household members applying for benefits is required on this form.

Name	Citizen or Alien*	Date of Birth	SSN#	Disabled (Y or N)	Alien#	Verification#

Signature of Adult _____

Worker _____ Cert. Location _____

Telephone: (___) _____ Case Number _____

DHS - 1926, rev 2/99

PART B: RESOURCES (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the questions below for everyone for whom you are applying. If applying for **Medical Assistance or Financial Assistance/TANF**, also provide resource information for the additional persons indicated on page 2 of this application. Include any resources anyone owns, is currently buying or has inherited. Include any resources jointly owned with someone else, even if that person does not live with you. List the names of all joint owners. After each joint owner's name, list the amount of the resource owned by that person. **Refer to #4 on the instruction page and talk to your worker if you need help answering these questions.**

YES ( ) NO ( ) 1. Cash on hand and not in a bank? If YES, list owner(s) _____ Amount _____

YES ( ) NO ( ) 2. Checking account, savings account, credit union account, Certificate of Deposit or money market account, patient funds for people in a nursing facility or Community Residence Facility (CRF)? List all accounts, even if there is no money in the account.

Owner	Type of Account Account #	Where	$ Amount	Date Acquired
Owner	Type of Account Account #	Where	$ Amount	Date Acquired

YES ( ) NO ( ) 3. Tax refunds, stocks or bonds, trust funds, pension plans, retirement accounts, promissory notes, or deeds of trust?

Owner	Type	Where	$ Amount	Date Acquired
Owner	Type	Where	$ Amount	Date Acquired

YES ( ) NO ( ) 4. Health Insurance?

Policy Holder	Company Name, Address, Phone	Begin Date End Date	ID Number Premium $	Type of Coverage	Person(s) Insured

YES ( ) NO ( ) 5. Medicare?

Person Insured	Claim Number	Check (✓) ( ) Part A ( ) Part B	Begin Date End Date	Premium $	Payment Method

YES ( ) NO ( ) 6. Life Insurance policies? (NOT REQUIRED FOR FOOD STAMP APPLICANTS WHO ARE NOT ELDERLY OR DISABLED)

Owner(s)	Person(s) Insured	Company Name, Address, Phone	Policy #	Cash Value

YES ( ) NO ( ) 7. Licensed or unlicenced vehicles, such as cars, trucks, vans, boats, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Year-make-model	License #	$ Value $ Amount Owed	How is vehicle used?	Date Acquired
Owner(s)	Year-make-model	License #	$ Value	How is vehicle used?	

YES ( ) NO ( ) 8. Personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, or supplies?

Owner	Type	YES ( ) NO ( ) Is this property necessary to your own business?	$ Value $ Amount Owed	Date Acquired
Owner	Type	YES ( ) NO ( ) Is this property necessary to your own business?	$ Value $ Amount Owed	Date Acquired

YES ( ) NO ( ) 9. Real property, including life estates, land, buildings, or mobile homes? If YES, do you live there? Check (✓) YES ( ) NO ( )

Owner	Type	YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	$ Value $ Amount Owed	Date Acquired
Owner	Type	YES ( ) NO ( ) Income producing YES ( ) NO ( ) Currently for sale	$ Value $ Amount Owed	Date Acquired

YES ( ) NO ( ) 10. Burial plots, burial arrangement or trust funds for burial?

Owner	Number of Plots, Type of Arrangement	Where	$ Value $ Amount Owed	Date Acquired
Owner	Number of Plots, Type of Arrangement	Where	$ Value $ Amount Owed	Date Acquired

YES ( ) NO ( ) 11. Has anyone sold, transferred, or given away any resources in the last 3 months if applying for Food Stamps? In the last 2 years, if applying for Cash Assistance/TANF or Medical Assistance?

Property Transferred		Value at Transfer	Amount Received	Explain Reason for Transfer
From Whom	To Whom	Date Acquired	Date Transferred	

YES ( ) NO ( ) 12. Does anyone expect to receive any money because of a legal suit involving a personal injury or property damage? If YES, explain.

YES ( ) NO ( ) 13. Does anyone expect a change in resources this month or next month? If YES, explain and give date change is expected.

PART C: INCOME (ALL APPLICANTS MUST COMPLETE THIS SECTION)

Answer the income questions for everyone for whom you are applying. Income means any money you received from working or money you received from any other source. If applying for Cash Assistance or **Medical Assistance,** also provide income information for the additional persons indicated on page 2 of this application. For **Financial Assistance** or **Medical Assistance** for children, also provide income information for the child's parent or stepparent living in the home. If the parent is a minor under age 18 (for **Financial Assistance**) or under age 21 (for **Medical Assistance, if applicable**), also provide income information for the parent of the minor parent.

1. Does anyone receive any of the following types of money from working? Check (✓) YES or NO for each type. If YES, give the information requested.

1. YES ( ) NO ( ) Wages/salary
2. YES ( ) NO ( ) Babysitting/Child care
3. YES ( ) NO ( ) Seasonal Work
4. YES ( ) NO ( ) Domestic Work
5. YES ( ) NO ( ) Odd Jobs
6. YES ( ) NO ( ) Other self employment
7. YES ( ) NO ( ) Other income from working?

If YES, specify:_____

Item #	Person Receiving Money from Working	Employer's Name, Address, Phone Number	Employment Begin Date	Hours Worked Per Month	Rate of Pay Per Hour	How Often Paid	Gross Monthly Pay Before Deductions
					$		$
					$		$

2. Does anyone receive any other type of money? Check (✓) YES or NO for each type. If YES, give the information requested.

1. YES ( ) NO ( ) Social Security
2. YES ( ) NO ( ) SSI
3. YES ( ) NO ( ) VA benefits
4. YES ( ) NO ( ) Retirement benefits
5. YES ( ) NO ( ) Public assistance
6. YES ( ) NO ( ) Child support/alimony
7. YES ( ) NO ( ) Unemployment benefits
8. YES ( ) NO ( ) Worker compensation
9. YES ( ) NO ( ) Tax Refunds
10. YES ( ) NO ( ) Prize winnings
13. YES ( ) NO ( ) Cash gifts/Contributions
14. YES ( ) NO ( ) Military allotment
15. YES ( ) NO ( ) Room/board income
16. YES ( ) NO ( ) Rental income
17. YES ( ) NO ( ) Insurance settlement
19. YES ( ) NO ( ) Training allowances
20. YES ( ) NO ( ) Loans
21. YES ( ) NO ( ) Other type of money?

If YES, specify:_____

Item #	Person Receiving Money	Type of Money Received	How Often Received	When Received	Gross Monthly Amount Before Deductions
					$
					$
					$

YES ( ) NO ( ) 3. Is anyone a veteran of the armed services? If YES, provide: Name:_____
Dated Served:_____ Serial #:_____

YES ( ) NO ( ) 4. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job or reduced hours worked in the last 60 days?

Name of Person	Employer's Name, Address, Phone	Employed From/To	Hrs./Wk. Worked	Rate of Pay	How Often Paid	Date Last Pay Received	Reason for Leaving, Reducing Hours
				$			

YES ( ) NO ( ) 5. Does anyone besides the people for whom you are applying pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills, or any other bills?

Person Receiving Help	Person Providing Help	Type of Help Received	Amount	Does Money Come Directly to You?	Is this a Loan?	Is Repayment Expected
			$	YES ( ) NO ( )	YES ( ) NO ( )	YES ( ) NO ( )

YES ( ) NO ( ) 6. Has anyone applied for or received student financial aid or work-study for a current school term at a college or university? Or, any school or training program beyond the high school level? Or, any school or training program for the physically or mentally disabled?

Name of Person	Type of Financial Aid	Amount	Period Covered	Tuition Fees	Books Supplies	Dependent Care	Room & Board	Other (Specify)
		$	From: To:	$	$	$	$	Item: $
		$	From: To:	$	$	$	$	Item: $

YES ( ) NO ( ) 7. Does anyone pay for dependent care expense for a child, an elderly person, or an adult with a disability?

Person Paying for Care	Person Receiving Care	Check (✓) If Disabled	Provider's Name, Address, Phone Number	Amount Paid
		( ) Disabled		$
		( ) Disabled		$

YES ( ) NO ( ) 8. Does anyone expect any change in the type of money received, employment, or hours worked, either this month or next month?
If YES, explain and give date: _____

YES ( ) NO ( ) 9. Does anyone pay legally obligated child support to someone not in the household? If YES, Person paying: _____
Person supported: _____ Amount paid, how often: $_____

YES ( ) NO ( ) 1. Does anyone who is included in this application have any unpaid medical bills for medical services that were received during the three months before the month of application? If YES, complete the boxes below.

Patient's Name	Kind of Medical Expense	Date of Service	Amount Owed	Amount Still Owed

YES ( ) NO ( ) 2. Have you or anyone for whom you are applying been hospitalized as the result of an accident in the last three months? If YES, comp the boxes below.

What Happened, Where, How	Name, Address of Person at Fault	Is a Liability Suit Planned o in Progress? YES ( ) NO
Name, Address of All Insurance Companies Involved	Name, Address, Phone Number of Your Attorney	

YES ( ) NO ( ) 3. Are you requesting Medical Assistance for the last three months prior to this application? If YES, answer the following questions?

YES ( ) NO ( ) a. Did your address change at any time during the last three months? If YES, describe the changes: _____

YES ( ) NO ( ) b. Was there any change in who was living with you doing this period? If YES, describe changes: _____

YES ( ) NO ( ) c. Was there any change in anyone's income or assets during this period? If YES, describe changes: _____

YES ( ) NO ( ) 4. **Answer Only If Someone Is Applying for Medical Assistance and Is Blind or Disabled:** Does this person have a work related expense? If YES, give amount and explain. _____

YES ( ) NO ( ) 5. Have you been informed about the Early Periodic Screening, Diagnosis and Treatment (ESPDT) or the Medicaid Well Child program

YES ( ) NO ( ) 6. Would you like a referral to be made to the ESPDT or Medicaid Well Child program?

YES ( ) NO ( ) 7. I understand that in the event of my death, the Department may make a claim against my estate for the amount of Medical Assistance paid on my behalf after my 65th birthday. The Department will not make a claim if I die leaving a surviving husband or wife or chil who is under age 21 or who is blind or permanently and totally disabled.

1. List each child for whom you are applying. Then, list the names of both parents. You must identify both parents in order to receive Cash Assistance.	2. Provide the appropriate CODE in the box below if either PARENT is: U.....Unemployed DI....Disabled DE...Deceased A.....Absent	Answer Questions 3 & 4 Only if the answer to Question 2 Is "Absent" 3. Reason for Absence: Provide the appropriate CODE in the box below for each absent parent. S....Separated P....No Paternity Established D....Divorced I.....Incarcerated D....Deserted	4. Financial Support: Does the absent parent regularly provide monthly financial support? Check (✓) YES or NO in the boxes provided below. If YES, give amount, and how often received.
Child's Name			
Mother			YES ( ) NO ( ) $.
Father			YES ( ) NO ( ) $
Child's Name			
Mother			YES ( ) NO ( ) $
Father			YES ( ) NO ( ) $
Child's Name			
Mother			YES ( ) NO ( ) $
Father			YES ( ) NO ( ) $
Child's Name			
Mother			YES ( ) NO ( ) $
Father			YES ( ) NO ( ) $
Child's Name			
Mother			YES ( ) NO ( ) $
Father			YES ( ) NO ( ) $

PART E: FOOD STAMPS

1. Provide the name of the person who is the head of your household in the box

HEAD OF HOUSEHOLD

YES ( ) NO ( ) 2. Would you like to name one or more authorized representatives who could apply for food stamps for you, pick up or receive food stamps for you, use your food stamps in grocery stores for you, or receive food stamp correspondence and notices for you?

	NAME, ADDRESS, PHONE NUMBER OF AUTHORIZED REPRESENTATIVE(S)	CHECK (✓) EACH DUTY AUTHORIZED FOR THAT PERSON	
1		( ) Apply for food stamps	( ) Use food stamps
		( ) Receive food stamps	( ) Receive correspondence
2		( ) Apply for food stamps	( ) Use food stamps
		( ) Receive food stamps	( ) Receive correspondence

An authorized representative must have written permission to apply for food stamps. This permission can be given in the space above or in a letter. Permission can only be given by the head of the household.

YES ( ) NO ( ) 3. Is anyone living in your home NOT included on your Food Stamp application? If YES, answer Question "a".

a. YES ( ) NO ( ) Do you and everyone for whom you are applying intend to purchase and prepare meals apart from these people?

YES ( ) NO ( ) 4. Is anyone age 60 or older, **OR** disabled? If disabled, identify the disability:_____

If YES, list below all the current medical expenses for these people, including Medicare premiums, other medical insurance premiums, medical and dental bills, prescription drugs, eyeglasses, dentures, hearing aids, transportation for medical services, nursing services, and any other medical bills. ALSO, indicate how you would like these medical expenses deducted in order to determine your food stamp benefits. TALK TO YOUR WORKER BEFORE SELECTING A METHOD OF DEDUCTION.

PERSON WITH EXPENSE	TYPE OF EXPENSE	AMOUNT	NAME, ADDRESS, PHONE NUMBER OF DOCTOR, HOSPITAL, PHARMACY	METHOD OF DEDUCTION
		$		( ) Lump Sum ( ) Monthly Average ( ) Expected Payment
		$		( ) Lump Sum ( ) Monthly Average ( ) Expected Payment
		$		( ) Lump Sum ( ) Monthly Average ( ) Expected Payment

FOOD STAMP EXPENSES

If you report and provide proof of your expenses shown in the Food Stamp Section, you will get the maximum amount of food stamps allowed. Failure to report or provide proof of your expenses will be regarded as your statement that you do not want to receive a deduction for the unreported or unproven expense. (Authority: United States Department of Agriculture Administrative Notice 6-99, issued January 4, 1999)

Applicant's or Authorized Representative's Signature or Authorized Mark	Date
Witness Signature to Mark or Interpreter	Date

YES ( ) NO ( ) 5. Does anyone have any shelter expense for rent or mortgage, real estate tax, property tax, home owner's insurance, electricity, gas, oil, water or sewer, or telephone? If YES, answer Questions "a" and "b". Then, give the information requested in the boxes.

a. YES ( ) NO ( ) Are any utilities included in your rent? If YES, leave the boxes for those expenses blank.

b. YES ( ) NO ( ) Are taxes or insurance included in your mortgage payment? If YES, leave those boxes blank.

Expense	Rent or Mortgage	Taxes	Insurance	Telephone	Electricity	Gas	Oil	Water/sewer
Amount Billed	$	$	$	$	$	$	$	$
How Often								
Who Pays Bill								

YES ( ) NO ( ) 6. Does anyone have or expect to have an expense for heating or cooling the home? Or, has anyone received assistance from the Fuel Assistance Program during this past year?

If YES, check (✓) whether you would like your food stamp benefits determined using your actual utility expenses or a standard amount we use for these expenses. TALK TO YOUR WORKER BEFORE ANSWERING. Actual Utility Expenses ( ) Utility Standard ( )

If the Utility Standard is selected, does anyone living in your home but not included on your Food Stamp application help you pay your heating or cooling bill? Check (✓) YES ( ) NO ( ) If YES, explain:_____

YES ( ) NO ( ) 7. Are you **temporarily** staying in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If YES, provide the date you moved in:_____

YES ( ) NO ( ) 8. Does anyone have a shelter expense for a home (rented or owned) that is temporarily not lived in because of employment or training away from the home, illness, or a disaster?

Reason for Not Living There	Does Person Intend to Return?	Type and Amount of Shelter Expenses	Is Someone Else Living There?	If Someone Else Lives There, Does That Person Pay Rent?
	YES ( ) NO ( )		YES ( ) NO ( )	YES ( ) NO ( )

CHANGES

You must report all required changes within the time limits required. The following examples do not include every change which you must report. If you are not sure whether to report a particular change, discuss this with your worker.

- **Food Stamps**

(REPORT CHANGES WITHIN 10 DAYS)

1) Change of address and any changes in shelter costs due to the move
2) Change in the persons in the household
3) Change in source of income, including getting a new job
4) Change in monthly income of more than $80
5) Change in resources
6) Change in motor vehicles owned
7) Change in legally obligated child support payments

- **Financial and Medical Assistance**

(REPORT CHANGES WITHIN 10 DAYS)

1) Change of address
2) Change in marital status
3) Change in the persons in the household
4) Child turns 18
5) Person in home is no longer disabled
6) Change in income
7) Change in resource
8) Change in motor vehicles owned
9) Change in dependent care expenses

PENALTIES FOR TANF VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF. If you are found guilty after an agency hearing or by the courts of intentionally breaking these rules, your needs will be removed from the grant for the following periods: 6 months (1st offense), 12 months (2nd offense), or permanently (3rd offense). Anyone convicted of misrepresenting their residence to get TANF in two or more states is ineligible for TANF for 10 years.

PENALTIES FOR FOOD STAMP VIOLATIONS

You must not give false information or hide information to get food stamps. You must not trade or sell food stamps or ATP/EBT cards. You must not change ATP/EBT cards to get food stamps you are not eligible to receive. You must not use food stamps to buy non-food items, such as alcohol, tobacco or paper products. You must not use someone else's food stamps or ATP/EBT card for your household.

Anyone who intentionally breaks any of these rules could be barred from the Food Stamp Program for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); is subject to a $250,000 fine, may be imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

Anyone who intentionally gives false information about his or residence to get Food Stamps in more than one locality at the same time could be barred for 10 years. Anyone convicted of trading or selling Food Stamps of $500.00 or more could be barred permanently. Anyone convicted of a drug related felony committed after August 22, 1996 could be barred permanently from receiving Foods Stamps.

INFORMATION ABOUT THE OFFICE OF PATERNITY AND CHILD SUPPORT ENFORCEMENT (OPCSE)

In order to receive TANF, you are required to assign all of your rights to financial support paid to you and to everyone else for whom you are receiving TANF. You must give to OPCSE any support payments you receive after you receive your first TANF check. By accepting the TANF check, you are agreeing to assign these rights and to cooperate with the agency efforts.

"GOOD CAUSE" WORK EXEMPTIONS

You must participate in a job search or another work activity as a condition of eligibility for benefits. You will not be required to participate if one or more of the following pertains to you.

- You have a child under age 1;
- You are age 60 or older;
- You are responsible for the care of a disabled child or adult relative in the home
- You or other household member(s) are ill which requires you to stay home;
- There is no adequate or affordable child care for your children under age six; or
- There is a family emergency such as a death in the family or other crisis, which is beyond your control and which

MEDICAID WELL-CHILD PROGRAM

The Well-Child Program provides free checkups and treatment to Medicaid eligible children under age 21. The Well-Child Program is very important and can be obtained from any doctor or clinic participating in the Medicaid program.
The Well-Child Program also helps in scheduling appointments and providing transportation to the doctor's office. For help in scheduling appointments and providing transportation call 1-800-MOM-BABY. For more information about the program, call (202) 727-0725.

RIGHT TO MEDICAL SERVICES

If during a period when you are eligible for Medicaid, the ELIGIBILITY VERIFICATION SYSTEM (EVS) informs you or your provider that you are not eligible for Medicaid and you dispute that determination, you may obtain free legal assistance by contacting Terris, Pravlik & Millian at 1121 12th Street, N.W. Washington, D.C., (202) 682-0578. Your provider has been instructed to call the EVS backup system.

MEDICAID RECERTIFICATION PROCESSING

You are responsible for submitting all of the documents and providing all of the information requested in connection with the recertification of your Medicaid eligibility. If you return all of the documents requested before the end of your current Medicaid eligibility period, the Department of Human Services MUST either approve or disapprove your request or continue your eligibility until a determination of ineligibility is made and you are given written notice of that decision. If you are determined no longer to be eligible for Medicaid, you have a right to request a hearing to challenge that determination. If you have not received written notice that your recertification has either been approved or denied by the end of your current eligibility period, and your eligibility has not been continued, you can obtain free legal assistance by calling the firm of Terris, Pravlik & Millian at 1121 12th Street, N.W. Washington, D.C., (202) 682-0578.

RIGHT TO A FAIR HEARING

If you are not satisfied with the Department's action on your application and the reason for this action, you may request a fair hearing within 90 days. You have the right to obtain legal counsel on your behalf. If you make a timely request for a hearing your benefits will continue until a hearing decision is rendered. If you do not make a timely request for a hearing, your benefits will not continue; however, you may within 90 days from the date of a notice request a hearing. Your worker will gladly answer questions concerning your application and the fair hearing process.

If you believe you have been discriminated against because of race, color, sex, national origin, or handicap you may file a complaint with the D.C. Department of Human Services or the Federal Department of Health and Human Services within 180 days from the date of receiving a notice from the Department on their decision regarding your eligibility for financial/medical assistance at this time, you may reapply if your situation changes.

ASSIGNMENT OF RIGHTS TO MEDICAL SUPPORT

In order to receive Medical Assistance/Medicaid, each person age 18 or older is required to assign all rights to medical support to the Department of Human Services. This means that you must give to the Department any payment for medical services you receive from another insurer. You are also required to assign these same rights for everyone for whom you have the legal rights to do so. Failure to assign your rights to medical support will make you ineligible for Medical Assistance/Medicaid. Failure to assign the rights of anyone else will not make that person ineligible.

DIRECTIONS: Use column A, initial one of the statements, and sign your name. Any other person age 18 or older should use column B, initial one of the statements, and sign his/her name.

A	B	
__	__	**I agree to assign my rights and the rights for everyone for whom I have the legal right to do so.**
__	__	**I refuse to assign my rights.**
__	__	**I refuse to assign the rights of: (give name)**_____

Signature A: _____

Signature B: _____

VOTER REGISTRATION

On Page 1 of this application, you were asked whether you would like to register to vote here today. **Your worker will check the statement below which applies to you.**

- ☐ **You indicated that you would like to apply to register to vote and a voter registration application form was given to you to complete. If you would like help in filling out the voter registration form, we will help you. The decision to accept help is yours. You also have the right to complete your voter registration application form in private.**
- ☐ **You are already registered to vote at your current address, you are not eligible to register to vote, or you otherwise do not want to apply to register to vote today.**
- ☐ **You did not respond when asked if you wanted to apply to register to vote. Your failure to respond indicates that you will be considered to have decided not to register to vote at this time.**

Applying to register or declining to register to vote will not affect the assistance or services provided to you by this agency. A decision not to apply to register to vote will remain confidential. A decision not to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with: The District of Columbia Board of Elections and Ethics, 441 4th Street, N.W., Suite 250, Washington, D.C. 20001 - Phone: 202/727-2525.

ACKNOWLEDGMENT OF TANF PROGRAM REQUIREMENTS

I acknowledge that the requirements of the Temporary Assistance to Needy Families (TANF) program have been explained to me. I understand that TANF is not an entitlement program and I have been informed of the limitations and penalties of the TANF program. Specifically, I have been made aware of the following provisions:

- 60 Month Lifetime Limit
- Teen Parent Home-Living Requirement
- Teen Parent School Attendance Requirement
- Parent May be Required to Look for Work Immediately and Sign Individual Plans that Describe the Steps He/She Must Take to Become Self-Sufficient
- Assignment of Support Rights
- Cooperation with the Child Support Agency
- 10 Year Ban for Misrepresenting Residence to Obtain Benefits in Two or More States
- Denial of Assistance for Fugitive Felons and Probation/Parole Violators
- Denial of Assistance for Minor Children Absent from Home in Excess of 90 Days

MY SIGNATURE ON PAGE 15 CERTIFIES THAT I HAVE READ AND UNDERSTAND THE TANF PROGRAM REQUIREMENTS.

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) –CUSTOMER/AGENCY AGREEMENT

I, _____, acknowledge that I must participate in job search or job readiness activities, as a condition of eligibility for TANF benefits. I understand that if I do not participate in these activities, my needs will not be reflected in my family's grant. If I am receiving assistance and I fail to comply with this agreement, I understand that my needs will not be reflected in my family's grant. Furthermore, I agree to take an active role in the development of my plan for self-sufficiency with District of Columbia Government staff, including the determination of long and short range goals that will enhance by ability to achieve self-sufficiency. I will advise the appropriate staff of the Income Maintenance Administration (IMA) and the Department of Employment Services (DOES) of any conflicts and emergencies which may require a change in my participation. I understand that I may be asked by the District of Columbia to sign an Individual Responsibility Plan and that my level of assistance will be based on compliance with that plan, once I have been determined eligible for TANF.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTAND THIS AGREEMENT.

BY MY SIGNATURE BELOW, I DECLARE UNDER PENALTY OF PERJURY THAT ALL OF THE FOLLOWING IS TRUE:

I UNDERSTAND:

- All of the information provided in this application.
- If I give false, incorrect, or incomplete information, including intentionally misidentifying the parent of a child, or do not report required changes on time, I may be breaking the law and could be prosecuted for perjury, larceny, or welfare fraud.
- If I helped someone complete this form so as to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility or recertification, including reviews by Quality Control, my benefits may be denied until I cooperate.

Everyone for whom I am applying is either a U.S. citizen or an alien in lawful immigration status, unless I am only applying for emergency medical services for which there is not a citizenship or lawful alien requirement. All information on this application is correct and complete to the best of my knowledge and belief, including information about citizenship and alien status.

MY SIGNATURE BELOW, AUTHORIZES THE RELEASE OF ALL INFORMATION, which will be considered confidential, to a representative of the Department of Human Services (DHS). All persons, firms, corporations, commissions, agencies and organizations of any kind, whether public or private, having knowledge of my financial, medical or other circumstances, are hereby authorized to answer in full any questions which may be asked by DHS of the applicant or recipient.

I filled in this application myself. YES ( ) NO ( ) If NO, it was read back to me when completed. YES ( ) NO ( )

Applicant's or Authorized Representative's Signature or Mark:	Date:	Spouse or Authorized Representative's Signature or Mark:	Date:
Witness Signature to Mark or Interpreter:	Date:	Worker's Signature:	Date:

Complete the box below if this application was completed by someone other than the applicant.

Person Completing Application:	Date:	Address:
Phone Number(s): (Home) (Work)		Relationship to Applicant:

TAB F

Documentation Guide
Immigrant Eligibility for Health Coverage in New York State

Listed below are immigration documents that can establish one's immigration status when applying for **public health coverage** in New York. These documents can also be used for the purposes of applying for other federal and state benefit programs. The categories of immigrants who are eligible will vary with each benefit program.

Immigrant Eligibility for Other Health Care Programs

New York State residents, regardless of their immigration status, are eligible for Child Health Plus B (CHPlus B), Prenatal Care Assistance Program (PCAP), Emergency Medicaid, and sliding-fee scale at the public hospitals and clinics. For each program, the immigrant must meet other eligibility criteria, including income requirements.

Category 1: U.S. Citizens

Category	Documents	WMS ACI code
U.S. Citizen (Includes the 50 States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, and Samoa or Swain's Island for purposes of Medicaid)	►U.S. Birth Certificate ►U.S. Passport ►Naturalization Papers of Certificate (N-550 or N-570) ►Consulate Report of Birth Abroad (FS-240) ►Certification of Report of Birth (DS-1350) ►U.S. Citizen I.D. Card (I-197 or I-179) ►Certificate of Citizenship (N-560 or N-561) ►Information from a primary source Federal agency (such as SSA) verifying U.S. as place of birth ►Religious document such as a baptismal record, recorded within 3 months of age showing the ceremony took place in the U.S. *Note: Listed are the most common documents used to prove citizenship. The list is not exhaustive and there are other documents that can establish citizenship.*	**C**

Satisfactory Immigration Status[1]

Category 2: Qualified Immigrants

Category	Documents	WMS ACI code
Lawful Permanent Residents (LPRs or "green card" holders)	►I-94 or passport stamped 1-551 ►I-551 Legal Permanent Resident Card "green card" (I-I51-older version) ►I-327 reentry permit ►I-181 Memorandum of Creation Of Lawful Permanent Resident with approval stamp	**K** (without 40 quarters) **OR** **S** (with 40 quarters)
Refugees	►I-94 or passport with annotation "Section 207" or "refugee" ►I-551 coded R8-6, RE6, RE7, RE8, or RE9 ►I-571 Refugee Travel Document ►I-688B or I-766 coded 274a.12(a)(3) or A3	**R**
Asylees	►I-94 or passport with annotation "Section 208" or "Asylee" ►I-551 coded AS6, AS7, or AS8 ►I-571 Refugee Travel Document ►I-688B or I-766 coded 274a.12(a)(5) or A5 ►Letter/order from the USCIS[2] or Court granting asylum	**A**

Category	Documents	WMS ACI code
Persons granted withholding of deportation or removal (Non-citizens whose deportation or removal has been withheld based on a finding that the person's life or freedom is threatened in the country of deportation based on race, religion, nationality, or membership in a particular social group or political opinion.)	►I-94 or passport stamped "Section 243(h)" or "Section 241(b)(3)" ►I-571 Refugee Travel Document ►I-688B or I-766 coded 274a.12(a)(10) or A10 ►Letter/order from USCIS or court granting withholding of deportation or removal	**J**
Parolees admitted into the U.S. for at least one year (Non-citizen who have been allowed to come into the U.S. for humanitarian or public interest reasons.)	►I-94 with annotation "Paroled Pursuant to Section 212(d)(5)" or "parole" or "PIP" with the date of entry and date of expiration indicating at least one year ►I-688B or I-766 coded 274a.12(a)(4), 274a.12(c)(11), A4, or C11, and I-94 indicating admitted for at least one year	**G**
Cuban/Haitian Entrants	►I-94 with annotation "Cuban-Haitian Entrant" or any notation indicating "parole" on or after 10/10/80* ►I-551 coded CU6, CU7, or CH6 ►I-688B or I-766 coded 274a.12(c)(8) or C8 ►Order to Show Cause (OSC)*, I-122, or Notice to Appear (NTA)* indicating pending exclusion, removal or deportation proceedings ►Any document indicating pending asylum application or filing of I-589 application for asylum* **Note: With reasonable evidence on the document that the person has been a national of Cuba or Haiti*	**H**
Amerasians	►I-94 or passport with the codes AM1, AM2, AM3, AM6, AM7, or AM8 ►I-551 coded AM1, AM2, AM3, AM6, AM7, or AM8	**R**
Conditional Entrants *(Status granted to refugees before 1980.)*	►I-94 or other document showing admission under Section 203(a)(7), "refugee conditional entry" ►I-688B or I-766 coded 274a.12(a)(3) or A3	**F**
Canadian born Native Americans	►I-94 coded S13 ►Tribal Record ►Birth or Baptismal Certificate issued on a reservation ►Letter from Canadian Department of Indian Affairs ►School Records	**C**
Native Americans belonging to a federally recognized Tribe born outside the U.S.	►Membership card or other tribal document demonstrating membership in U.S. federally-recognized Tribe	**C**
Certain battered spouses and children who have been granted, or found prima facie eligible for relief under the Violence Against Women Act (VAWA)	►I-797 indicating approved, pending, or prima facie determination of I-360 (Petition by self-petitioning Immigrant of abusive USC or LPR) under Section 204(a)(1)(iii) or (iv), or Section 204(a)(1)(B)(ii) or (iii) ►I-797 indicating approved or pending I-130 (visa petition) under Section 204(a)(1)(A)(i) or (ii), or Section 204(a)(1)(B)(i) ►Order from EOIR granting or establishing prima facie determination of suspension of deportation under Section 244(a)(3) or cancellation of removal under Section 240A(b)(2)	**B**
Victims of Trafficking (Victims of Trafficking (T visa) receive benefits to the same extent as refugees (GIS 02 MA/022).	►I-94 coded T1, T2, T3, T4, T5 ►Certification letter (for adults) or eligibility letter (for children) from Office of Refugee Resettlement ►I-797 Notice of Action	**R-NYC** **D-Upstate**
Veterans or Persons on active duty in the Armed Forces and their immediate family members (Immediate family members: documentation of relationship to veteran or person on active duty)	►Original or notarized copy of current orders showing the person is on full-time duty in U.S. Armed forces ►Military I.D. card - DD Form 2 (active) ►DD Form 214 showing "Honorable" discharge ►Original or notarized copy of the veteran's discharge papers	**V** **OR** **M**

Category 3: Persons who are Permanently Residing Under Color of Law (PRUCOL)*

*PRUCOL is not an immigration status. PRUCOL is not granted by the USCIS. PRUCOL is a public benefits eligibility category.

Category	Documentation	WMS ACI code
a. Parolees admitted into U.S. for less than a year	►I-94 with annotation "Paroled Pursuant to Section 212(d)(5)" or "parole" or "PIP" ►I-688B or I-766 coded 274a.12(a)(4), 274a.12(c)(11), A4, or C11	**T**
b. Persons under an Order of Supervision *(Non-citizens who have been found deportable; however certain factors exist which make it unlikely that USCIS would be able to remove them.)*	►I-94 annotated "Order of Supervision" ►I-220B Order of Supervision ►I-688B or I-766 coded 274a.12 (c)(18) or C18	**O**
c. Persons granted indefinite stay of deportation *(Non-citizens who have been found deportable, but USCIS deferred deportation indefinitely due to humanitarian reasons.)*	►I-94 coded 106 ►Letter/order from the USCIS or Court granting indefinite stay of deportation	**O**
d. Persons granted indefinite voluntary departure *(Status that was granted before 1996 to non-citizens who have been found deportable, but the USCIS deferred deportation indefinitely due to humanitarian reasons.)*	►I-94 or letter/order from the USCIS or Court granting voluntary departure for an indefinite time period	**O**
e. Persons on whose behalf an immediate relative petition has been approved and her/his families covered by the petition *(Non-citizens who are immediate relatives (spouse, father, mother, or unmarried child under 21) of a U.S. citizen/LPR who has filed an I-130 on their behalf.)*	►I-94 and/or I-210 indicating departure on a specified date, however, the USCIS expects the non-citizen's visa will be available within this time ►I-797 indicating I-130 petition has been approved ►Also see documentation listed under category "I"	**O**
f. Persons who have filed applications for adjustment of status under Section 245 of the INA and the USCIS has accepted as "properly filed" *(Non-citizens who filed for legal permanent resident status.)*	►I-94 or passports with annotation "adjustment application" or "employment authorized during status as adjustment applicant" ►I-688 or I-688A coded 245A ►I-688B or I-766 coded 274a.12 (c)(22) or C22 ►Also see documentation listed under category "I"	**O**
g. Persons granted stays of deportation *(Non-citizens who have been found deportable, but the USCIS may defer deportation for a specified period of time due to humanitarian reasons.)*	►I-94 or letter/order from the USCIS or Court indicating granted stay of deportation	**O**
h. Persons granted voluntary departure under Section 242(b) *(This section has been repealed.)*	N/A	**O**
i. Persons granted deferred action status	►I-797 or any document from USCIS granting deferred action status ►I-688B or I-766 coded 274a.12 (c)(14) or C14	**O**
j. Persons who entered and continuously resided in the U.S. before January 1, 1972 (Registry) *(Non-citizens are presumed by the USCIS to meet certain criteria for legal permanent residence.)*	►Any documentary proof establishing entry and continuous residence ►I-688B or I-766 coded 274a.12(c)(16) or C16 ►I-797, letter/notice from the USCIS or Court indicating registry application is pending	**O**

Category	Documentation	WMS ACI code
k. Persons granted suspension of deportation pursuant to Section 244 of the INA; the USCIS does not contemplate enforcing departure *(Non-citizens in this category have been found deportable, have met a period of continuous residence and have **filed** an application for the USCIS to suspend deportation, which has been granted.)*	►I-797, letter/order from an immigration judge and ►I-94 showing suspension of deportation granted. After Lawful Permanent Residence is granted the person will have a "green card" (Form I-551).	**O**
l. Other Persons living in the U.S. with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing: Examples include, but are not limited to: -Permanent nonimmigrants, pursuant to P.L. 99-239 (applicable to citizens of the Federated States Micronesia and Marshall Islands[5]); -Applicants for adjustment of status[1], asylum[2], suspension of deportation or cancellation of removal[3] or for deferred action -Persons granted extended voluntary departure[4] or Deferred Enforced Departure (DED)[4] due to conditions in their home country; -Persons granted Temporary Protected Status[7]; and -Persons having a "K", "V", "S" or "U" visa.	►I-94 coded K3, K4, V1, V2, or V3, T*, U, or S (refer to Category 4: "SPECIAL NONIMMIGRANT" section below) ►I-688B or I-766 coded 274a.12(a)(8)[5], 274a.12(a)(11)[4], 274a.12(a)(13)[6], 274a.12(c)(8)[2], 274a.12(c)(9)[1], 274a.12(c)(10)[3], 274a.12(c)(12)[6], A8[2], A9, A11[4], A13[6], C8[2], C9[1], or C12[6], 274a.12(a)(12) or (c)(19), A12, C19[7] ►I-688 or I-688A ►I-797 indicating the USCIS has received, taken action on or approved an application or petition ►Postal Return Receipt addressed to the USCIS or copy of cancelled check to the USCIS, and copy of the enclosed documents submitted to the USCIS, or ►Correspondence to or from the USCIS, showing that the person is living in the U.S with the knowledge and permission or acquiescence of the USCIS, and the USCIS does not contemplate enforcing the person's departure from the U.S.	**O**

Category 4: Non-Immigrants

Category	**Documentation**	WMS ACI code
Temporary Non-immigrants include: Visitors for business or pleasure (B-1, B-2), crewmen on shore leave (D), foreign students (F), temporary workers (H & O), including agricultural contract workers, members of foreign government representatives on official business (A), personnel of international organizations (G), Treaty Traders and investors (E), Cultural Exchange Visitors (Q), Athletes and entertainers (P), Religious workers (R), Exchange visitors (J) and members of the foreign press (I). *(These non-immigrants are lawfully admitted to the U.S. for a temporary or specified period of time.)*	►I-94, Arrival/Departure record ►I-185, Canadian Border Crossing Card* ►I-186, Mexican Border Crossing Card* ►I-444, Mexican Border Visitor's Permit* ►I-95A, Crewmen's Landing Permit *B-1/B-2 Visa/BCC is now issued in place of these documents	**E** **Emergency services only**
Special Non-immigrants: Some categories of non-immigrant status allow the status holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for the adjustment to LPR status after he or she has had the nonimmigrant status for a period of time. **As SPECIAL NONIMMIGRANTS [Law found at 8 U.S.C. Sect 1101 (a) (15) (K) (S) (T)* (U) and (V) visa holders are PRUCOL and are eligible for Medicaid/FHPlus/CHPlus A.** * Victims of Trafficking (T) receive benefits to the same extent as refugees (GIS 02 MA/022).	►I-94 coded K3, K4, V1, V2, or V3, T*, U, or S ►I-797 indicating the USCIS has received, taken action on or approved an application or petition ►Postal Return Receipt addressed to the USCIS or copy of cancelled check to the USCIS and a copy of the enclosed documents submitted to the USCIS, or ►Correspondence to or from the USCIS, showing that the person is living in the U.S. with the knowledge and permission or acquiescence of the USCIS, and the USCIS does not contemplate enforcing the person's departure from the U.S.	**O** **PRUCOL** *(EXCEPT VICTIMS OF TRAFFICKING)

Category 5: Undocumented Immigrants

Category	Documentation	WMS ACI code
Undocumented Immigrants *(Undocumented immigrants do not have the permission of the USCIS to remain in the U.S. They may have entered the United States legally but have violated the terms of their status, e.g. over-stayed a visa, or they may have entered without documents.)*	Undocumented immigrants are unable to provide documentation of immigration status; therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition. Undocumented children may be eligible for CHPlus B. Undocumented pregnant women continue to be eligible for PCAP.	**E** Emergency services only

U. S. Citizenship and Immigration Services (USCIS) Documents

I-94	Arrival Departure Card	**I-571**	Refugee Travel Document
I-181	Memorandum Of Creation of Record of Lawful Permanent Residence	**I-688**	Temporary Resident Card
I-210	Voluntary Departure	**I-688A**	Employment Authorization For Legalization Applicants
I-220B	Order of Supervision	**I-688B**	Employment Authorization Card
I-130	Petition for Alien Relative	**I-766**	Employment Authorization Card
I-140	Immigrant Petition for Alien Worker	**I-797**	Notice of Action (I-797C current version)
I-327	Reentry Permit for permanent residents	**DD-Form 2**	Military Identification Card
I-551	Legal Permanent Resident Card, Resident Alien Card or "green card"	**DD-214**	Report of Separation Military Discharge Document

[1]Satisfactory immigration status is an immigration status that makes the individual eligible for benefits under the applicable program.

[2]The United States Citizenship and Immigration Services (USCIS) was formerly the Immigration and Naturalization Services (INS) and the Bureau of Citizenship and Immigration Services (BCIS).

PLEASE NOTE:

The DATE OF ELIGIBILITY is the DATE OF ENTRY or the DATE STATUS WAS GRANTED. The date of entry is optional for "O" PRUCOL category immigrants.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

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Executive Deputy Commissioner

ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 04 OMM/ADM-7

TO: Commissioners of Social Services

DIVISION: Office of Medicaid Management

DATE: October 26, 2004

SUBJECT: Citizenship and Alien Status Requirements for the Medicaid Program

SUGGESTED DISTRIBUTION:
Medicaid Staff
Temporary Assistance Staff
Legal Staff
Fair Hearing Staff
Staff Development Coordinators

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ATTACHMENTS: See Appendix I for a listing of attachments

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
			P.L.103-322		
88 OMM/ADM-22		351.2(c)	P.L.104-193		
92 OMM/ADM-10		360-1.2	P.L.104-208		
00 OMM/ADM-9	00 OMM/ADM-9	360-3.2(j)	P.L.105-33		
	GIS 01 MA/015		P.L.106-386		GIS 01 MA/026
	GIS 01 MA/025		SSA 1903(v)(3)		GIS 01 MA/030
	GIS 02 MA/022		SSL 134-a(2), 122		GIS 01 MA/033
	GIS 02 MA/027		Aliessa v. Novello		GIS 02 MA/002
	GIS 03 MA/005		96 NY2d 418 (2001)		GIS 02 MA/016
	GIS 03 MA/011				GIS 03 MA/007
	GIS 03 MA/015				GIS 03 MA/008
	GIS 04 MA/003				GIS 04 MA/002
	GIS 04 MA/016				GIS 04 MA/014

APPENDIX I

Attachment A-1	Agency Letter Request for Social Security Number
Attachment A-2	Social Security Number Attestation Form
Attachment B-1	PRUCOL Narrative
Attachment B-2	Documentation Guide For PRUCOL Alien Categories
Attachment C	Aliens: Qualified/PRUCOL: Alien/Citizenship Codes(ACI Codes)
Attachment D-1	Documentation Guide Immigrant Eligibility for Health Coverage in New York State
Attachment D-2	Secondary Documentation of U.S. Citizenship
Attachment D-3	Key to I-766, I-688B Employment Authorization Documents (EAD)
Attachment D-4	Key to I-94 Arrival Departure Record
Attachment E-1	DSS 3955-Certification of Treatment for Emergency Medical Condition (Upstate) (9/04)

I. PURPOSE

The purpose of this Office of Medicaid Management Administrative Directive (OMM/ADM) is to provide local Departments of Social Services (LDSS) with a comprehensive document that clarifies and defines the various types of immigration statuses. This ADM outlines the citizenship/immigration documentation requirements for individuals in the Medicaid program, and provides specific desk aids that identify the United States Citizenship and Immigration Services (USCIS) codes which are important to the eligibility worker when determining the appropriate Medicaid coverage to be provided. In addition, this directive also defines otherwise eligible immigrants who are "Permanently Residing in the United States Under Color of Law" (PRUCOL) and those immigrants who are in satisfactory immigration status.

II. BACKGROUND

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L.104-193 (PRWORA-Welfare Reform) substantially restricted immigrants' eligibility for means-tested benefits programs, including Medicaid.

Prior to PRWORA, immigrants were eligible for full Medicaid coverage only if they were lawfully admitted for permanent residence or permanently residing in the United States under color of law (PRUCOL immigrants). The PRWORA created new eligibility criteria for immigrants. The previous "PRUCOL" categories were no longer relevant to determining an immigrant's eligibility for benefits. After the enactment of Welfare Reform, states could choose to cover the cost of these benefits with state-only money. New York opted not to do so, with certain exceptions, and enacted a statute conforming to the federal act (Social Services Law (SSL) Section 122).

On June 5, 2001, the New York State Court of Appeals decision, Aliessa v. Novello, held Social Services Law Section 122 unconstitutional to the extent it denied Medicaid to lawful permanent residents and persons "permanently residing under color of law" (PRUCOL). The Aliessa decision restored Medicaid coverage in New York State to both lawful permanent residents who came to the United States on or after August 22, 1996 and PRUCOLs regardless of when they entered the U.S. As a result of the ruling, New York must now provide Medicaid coverage to lawful immigrants who meet the Medicaid program's other eligibility criteria. The Aliessa decision does not cover undocumented immigrants or other temporary nonimmigrants (i.e., short term visa holders; foreign students; tourists) who remain eligible only for the treatment of an emergency medical condition.

Therefore, the local Departments of Social Services were notified that effective June 1, 2001, State and local Medicaid eligibility, for otherwise eligible immigrants, was no longer dependent on whether the immigrant was a qualified or non-qualified immigrant or the date on which the immigrant entered the United States.

As a result of the Aliessa decision, districts must not deny, reduce or discontinue qualified immigrants' and PRUCOL immigrants' eligibility for Medicaid, Family Health Plus or Child Health Plus A based on SSL Section 122.

III. PROGRAM IMPLICATIONS

This ADM explains the categories of immigrant and nonimmigrant statuses that local district eligibility workers need to know and understand in order to determine which Medicaid eligibility coverage is available to the applicant. Specific definitions of common immigration categories/terms and USCIS coding are essential tools that will aid the eligibility worker. Clarification of the Welfare Management System (WMS) process for authorizing Medicaid benefits to non-citizen applicants is important for workers to understand so as to insure proper reimbursement of State and/or federal shares.

Immigrants who are "qualified immigrants" (as defined in the definition section of this directive) and who are otherwise eligible, may receive full Medicaid benefits with Federal Financial Participation (FFP). In addition, otherwise eligible qualified immigrants who entered the United States on or after August 22, 1996 and who, prior to Aliessa, were eligible for Medicaid only after five years, can be eligible for full Medicaid benefits with State and local funds. In addition, otherwise eligible immigrants who are PRUCOL can be eligible for full Medicaid benefits with State and local funds. Temporary nonimmigrants and undocumented immigrants are not PRUCOL and continue to be limited to Medicaid coverage for care and services necessary for the treatment of an emergency medical condition.

Two groups of immigrants, given special exemption under SSL Section 122(1)(c), will continue to receive full Medicaid benefits with State and local funds to the extent they are otherwise eligible: 1.) Immigrants who, on August 4, 1997, were residing in certain residential facilities and receiving Medicaid based on a determination that they were PRUCOL; and 2.) Immigrants who, on August 4,1997, had been diagnosed with AIDS, as defined in Section 2780(1) of the Public Health Law, and were receiving Medicaid based on a determination that they were PRUCOL.

For some immigrants the United States Citizenship and Immigration Services (USCIS) (formerly the Bureau of Immigration and Naturalization Services [INS]) requires an Affidavit of Support (I-864). An Affidavit of Support is a USCIS form signed by an immigrant's sponsor. In the Affidavit of Support, the sponsor promises to financially support the immigrant if the USCIS allows the immigrant into the country. Presently, neither sponsor deeming nor sponsor liability is being used in the New York State Medicaid Program. The sponsor's income is not currently counted toward the immigrant applying for health coverage, nor is New York State requiring sponsors to repay Medicaid for services used by the immigrant. However, NYS Medicaid may implement these provisions at a future date.

NOTE: The provisions of this directive do **not** apply to pregnant women. A woman with a medically verified pregnancy is not required to document citizenship or immigration status for the duration of her pregnancy, through the last day of the month in which the 60-day postpartum period ends.

IV. REQUIRED ACTION

This directive provides the necessary tools a Medicaid eligibility worker needs to properly determine a Medicaid applicant/recipient's immigration status. By becoming familiar with the United States Citizenship and Immigration Services (USCIS) documents and codes, definitions, and the Welfare Management System's(WMS) Alien/Citizenship (ACI) Codes, Coverage Codes and State/Federal Charge Codes, a worker will be able to effectively determine a citizen's or immigrant's eligibility for Medicaid.

All legal immigrants are eligible for Medicaid, Family Health Plus and Child Health Plus A, as long as the applicant meets the other eligibility requirements of the program and have "satisfactory immigration status". The Federal definition of "satisfactory immigration status" is an immigration status that does not make the individual ineligible for benefits under the applicable program.

Examples of individuals who are said to be in "satisfactory immigration status" are:

- U.S. Citizens;
- Nationals;
- Native Americans;
- Immigrants lawfully admitted for permanent residence (LPR) and immigrants known as "qualified immigrants"; and
- Immigrants permanently residing in the United States under color of law (PRUCOL).

Only two groups of immigrants are ineligible for "full" Medicaid. Those are:

- Undocumented immigrants (i.e. persons with no USCIS paperwork)
- Temporary nonimmigrants (i.e. short term visa holders, foreign students, tourists)

However, providing they meet the other eligibility criteria, undocumented immigrants and temporary nonmmigrants may be eligible for the treatment of an emergency medical condition.

Districts must accept and process new and pending Medicaid applications submitted by or on behalf of all persons in satisfactory immigration status, including PRUCOL immigrants and immigrants formerly subject to the five-year rule. These Medicaid applications must be processed within the time frames specified in 18 NYCRR 360-2.4, which requires the social services district to make a Medicaid eligibility determination within 30, 45, or 90 days depending upon the applicant's eligibility category, and Section 365-a (6) of the Social Services Law, which directs the district to provide prenatal care assistance program Medicaid benefits presumptively to eligible pregnant women.

A. DEFINITIONS

This section provides or lists definitions for immigration statuses, immigration-related terms and public benefit terms that appear repeatedly throughout this directive.

ACTIVE MILITARY DUTY: The term "active military duty" applies to individuals in current full-time service in the Army, Navy, Air Force, Marine Corps, or Coast Guard. Members of the National Guard are not included in this definition.

ALIEN: The term "alien" means any person not a citizen or national of the United States. For the purposes of this directive, the term "immigrant" has the same meaning as the term "alien".

BATTERED IMMIGRANT: The term "battered immigrant" applies to certain individuals based on the fact that s/he was battered or subjected to extreme cruelty by a spouse or parent and who have been granted, or found prima facie eligible for relief under the Violence Against Women Act of 1994(P.L. 103-322).

EMERGENCY MEDICAL CONDITION: The term "emergency medical condition" means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

-placing the person's health in serious jeopardy;
-serious impairment to bodily functions; or
-serious dysfunction of any bodily organ or part.

Treatment of emergency medical conditions does not include care and services related to an organ transplant procedure.

NATIONAL: A "national" is a person, who is not a U.S. citizen, but who owes permanent allegiance to the United States and may enter and work in the U.S. without restriction. A "national" who is otherwise qualified may, if he becomes a resident of any State, be naturalized upon completing the applicable requirements. Examples of nationals are: (1) persons born in American Samoa and Swain's Island after December 24, 1952; and (2) residents of the Northern Mariana Islands who did not elect to become U.S. citizens.

NATIVE AMERICAN BORN IN CANADA: A Native American born in Canada may freely enter and reside in the United States and is considered to be lawfully admitted for permanent residence if he or she is of at least one-half Native American Indian blood. As such, he or she is a qualified immigrant. This does not include a non-citizen spouse or child of such Native American or a non-citizen whose membership in an Native American Indian tribe or family is created by adoption, unless such person is at least 50 percent Native American Indian blood.

NONIMMIGRANT: A "nonimmigrant" is defined as an individual who has been granted a nonimmigrant status that allows him or her to remain in the U.S. temporarily for a specific purpose. There are more than two dozen nonimmigrant categories, each of which has specific requirements concerning the purpose of the individual's stay in the U.S. Most nonimmigrant categories require as a condition of the status that the individual have the intent of returning to a residence abroad.

PRUCOL (**P**ermanently **R**esiding **U**nder **C**olor **O**f **L**aw): Any immigrant who is permanently residing in the United States with the **knowledge and permission or acquiescence** of the United States Citizenship and Immigration Services (USCIS)(formerly the Immigration and Naturalization Services [INS]) and whose departure from the United States the USCIS does not contemplate enforcing.

QUALIFIED IMMIGRANT: For the purposes of this directive, the term "qualified immigrant" has the same meaning as the term "qualified alien", as used in the federal PRWORA (Welfare Reform). Qualified immigrants are immigrants who usually live and work in the United States with the permission of the United States Citizenship and Immigration Services (USCIS).

SATISFACTORY IMMIGRATION STATUS: The term "satisfactory immigration status" is defined as an immigration status that does not make the individual ineligible for benefits under the applicable program. All qualified immigrants and PRUCOL immigrants are individuals said to be in satisfactory immigration status, as are citizens, Native Americans and nationals. The only groups excluded are undocumented immigrants and temporary nonimmigrants.

SPECIAL NONIMMIGRANT: Some categories of "special" nonimmigrant statuses allow the status (visa) holder to work in the United States and eventually adjust to lawful permanent residence status. These categories allow the individual to apply for adjustment to Lawful Permanent Resident (LPR) status after he or she has had the non-immigrant status for a period of time.

TEMPORARY NONIMMIGRANT: A temporary nonimmigrant is an immigrant who has been allowed to enter the United States for a specific purpose and for a limited period of time. There are more than two dozen nonimmigrant categories, each of which has specific requirements concerning the purpose of the individual's stay in the U.S. Examples include tourists, students, and visitors on business or pleasure.

UNDOCUMENTED IMMIGRANT: Undocumented immigrants are immigrants who do not have the permission or acquiescence of the United States Citizenship and Immigration Services (USCIS) to remain in the United States. They may have entered the United States legally but have violated the terms of their status, e.g., over-stayed a visa, or they may have entered without documents.

UNITED STATES CITIZEN: For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medicaid eligibility.

VETERAN: The term veteran means a person who served in the active military, naval or air service of the United States who fulfilled the minimum active duty service requirements and was honorably discharged or released, not on account of immigration status.

VICTIMS OF A SEVERE FORM OF TRAFFICKING: A "victim of a severe form of trafficking" is defined as anyone who:

1) has been subjected to a "severe form of trafficking in persons" which is defined as "sex trafficking in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age; or the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery; and
2) has not attained the age of 18 years or who is the subject of a certification issued by the federal government pursuant to Section 107(b)(1)(E) of the Victims of Trafficking and Violence Protection Act of 2000 (P.L. 106-386).

B. DOCUMENTATION AND VERIFICATION REQUIREMENTS

This directive will instruct social services district workers regarding the types of documentation that can be used to establish a Medicaid applicant's or recipient's immigration status and the individual's eligibility for Medicaid. This documentation is fully outlined in the "Documentation Guide, Immigrant Eligibility for Health Coverage in New York State", which is Attachment D-1 to this directive. As a general rule, U.S. citizens, nationals, Native Americans, qualified immigrants and PRUCOL applicants for Medicaid must provide appropriate documentation of their citizenship or satisfactory immigration status. In addition to the standard Medicaid eligibility questions regarding income, resources, family composition and living arrangements, the Medicaid program must ask an immigrant to verify his or her satisfactory immigration status. Such individuals must also sign a declaration, under penalty of perjury, that they are U.S. citizens, nationals, Native Americans, qualified or PRUCOL immigrants and must provide, or apply for, a Social Security Number or proof that s/he has applied for one, or tried to apply for a Social Security Number.

NOTE: Immigrant parents applying for Medicaid for citizen children do not have to supply any information about their own immigration status. Parents only have to prove that the child is a U.S. citizen. Pregnant women are not required to document their immigration status, complete the citizenship declaration, or provide a Social Security Number. In the month following the month in which the 60 day postpartum period ends, the women must meet these and all other applicable requirements in order to remain Medicaid eligible.

C. ELIGIBILITY FOR MEDICAID BENEFITS: CITIZENS, NATIONALS AND NATIVE AMERICANS

1. CITIZENS

Natural born citizens and individuals who acquire citizenship through naturalization and who are residents of the State of New York may receive Medicaid benefits, if otherwise eligible. For the purposes of qualifying as a United States citizen, the United States includes the 50 states, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands and the Northern Mariana Islands. Nationals from American Samoa or Swain's Island are also regarded as United States citizens for the purpose of Medicaid eligibility.

The following are examples of items which constitute primary documentation of U.S. citizenship (See Attachment D-1 to this directive):

- U.S. Birth Certificate
- U.S. Passport
- Naturalization Papers or Certificate (N-550 or N-570)
- Consulate Report of Birth Abroad (FS-240)
- Certification of Report of Birth (DS-1350)
- U.S. Citizen I.D. Card (I-197 or I-179)
- Information from a primary source Federal agency (such as SSA) verifying U.S. as place of birth
- Religious document such as baptismal record, recorded within 3 months of age showing the ceremony took place in the U.S.

Many elderly individuals born in rural areas of the United States have particular difficulty in documenting their place of birth. Districts must provide assistance to such persons in exploring all possible sources of primary and secondary verification before denying such individuals on the basis of citizenship status.

When primary documentation is not available, secondary documentation must be obtained. At least **two** secondary documents are needed to establish United States citizenship.

The following are examples of items which constitute secondary documentation of U.S. citizenship:

a.) Letter of No Record: This is a letter that indicates an attempt was made to find a birth certificate. It is issued by the State where the individual was born stating the name, date of birth, years searched for a record and that there is no birth certificate on file for the person; **AND**,

b.) One other document showing place of birth in the U.S. such as:

- Census record*
- Certificate of circumcision*
- Early school record*
- Family Bible record*

- Doctor's record of post-natal care*
- A notarized affidavit from a blood relative familiar with the circumstances of the birth, i.e. a parent, aunt, uncle, sibling.
- A delayed birth certificate filed more than one year after birth listing the documentation used to create it. It must be signed by the attending physician or midwife or list an affidavit by the parent(s) or show early public school records.

*Any of this documentation **MUST** be a record showing the date and place of birth and created within the first five years of life.
(Please refer to Attachment D-2 "Secondary Documentation of U.S. Citizenship".)

2. **NATIONALS**

All U.S. citizens are also called nationals of the United States, but some individuals who are U.S. nationals are not U.S. citizens. When the U.S. acquired certain island territories, Congress provided for the inhabitants of these territories to be citizens of their own islands, and nationals of the United States. Noncitizen nationals owe permanent allegiance to the U.S and may enter and work in the U.S. without restriction. At present, noncitizen nationals include only (1) certain citizens of American Samoa and Swain's Island, and (2) residents of the Northern Mariana Islands who did not elect to become U.S. citizens.

3. **NATIVE AMERICANS**

Native Americans born in the United States are citizens of the United States, and will have the same types of documentation as do other citizens.

A non-citizen member of a federally recognized tribe or a native-American who is at least fifty percent Native American Indian blood and who was born in Canada may be eligible for Medicaid benefits.

A Native American born in Canada may freely enter and reside in the U.S. and is considered to be lawfully admitted for permanent residence if she/he is of at least one-half Native American Indian blood. As such, she/he is a qualified immigrant. This does not include a non-citizen spouse or child of such Native American or a noncitizen whose membership in a Native American Indian tribe or family is created by adoption unless such person is at least fifty percent Native American Indian blood.

The following items can be used to verify Native American or federally recognized tribal membership:

Native Americans born in Canada:

- Birth or baptismal certificate issued on a reservation;
- Tribal records;
- Letter from the Canadian Department of Indian Affairs; or
- School records.

Non-citizen member of federally recognized tribe:

- Membership card or other tribal document; or
- Confirmed by contact with tribal government.

D. ELIGIBILITY OF IMMIGRANTS FOR MEDICAID BENEFITS: QUALIFIED IMMIGRANTS

As a result of the Aliessa v. Novello court decision, all qualified immigrants regardless of their date of entry into the United States, can be eligible for Medicaid provided they meet all other eligibility requirements. The only difference is that Federal Financial Participation (FFP) should be claimed for some groups but must not be claimed for others until they have resided in the United States as qualified immigrants for five years.

- Qualified immigrants who entered the U.S. prior to August 22, 1996 receive full Medicaid coverage with Federal Financial Participation (FFP);
- Certain qualified immigrants who entered the U.S. on or after August 22, 1996 receive Medicaid coverage with FFP; and
- Certain qualified immigrants who entered the U.S. on or after August 22, 1996, receive Medicaid coverage with State and local funds (FNP) until they have resided in the U.S. as qualified immigrants for five years.

Therefore, to assure proper claiming it is imperative that local department of social service staff determine and enter into the Welfare Management System (WMS) the correct Date of Entry (DOE).

Qualified immigrants include the following: (See Attachment D-1)

- Persons lawfully admitted for permanent residence;
- Persons admitted as refugees;
- Persons granted asylum;
- Persons granted status as Cuban and Haitian entrants;
- Persons admitted as Amerasian immigrants;
- Persons whose deportation has been withheld;
- Persons paroled into the United States for at least one year;
- Persons granted conditional entry;
- Persons determined to be battered or subject to extreme cruelty in the United States by a family member;
- Victims of trafficking; or
- Veterans or persons on active duty in the Armed Forces and their immediate family members.

1. **QUALIFIED IMMIGRANTS WHO ENTERED THE U.S. PRIOR TO AUGUST 22, 1996:**

   A qualified immigrant who entered the United States prior to August 22, 1996, may receive all care and services available under the Medicaid program, provided he or she is determined to be otherwise eligible. This provision includes individuals who attained qualified immigrant status subsequent to August 22, 1996, and who can demonstrate to the district's satisfaction that they continuously resided in the United States until attaining qualified immigrant status. Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified immigrants.

2. **QUALIFIED IMMIGRANTS WHO ENTERED THE U.S. ON OR AFTER AUGUST 22, 1996 AND ARE IN CERTAIN CATEGORIES EXEMPT FROM THE FEDERAL FIVE YEAR BAN ON MEDICAID:**

   The following qualified immigrants who entered the United States on or after August 22, 1996, may receive all care and services available under the Medicaid program, provided they are determined to be otherwise eligible.

   - Persons who have been granted asylum under Section 208 of the INA;
   - Persons for whom deportation has been withheld under Section 243(h) or 241 (b) (3) of the INA;
   - Persons who are Cuban and Haitian entrants (as defined in Section 501(e) of the Refugee Education Assistance Act of 1980);
   - Qualified immigrants lawfully residing in the State who are on active duty in the armed forces, or who have received an honorable discharge from the armed forces and their spouses and unmarried dependent children, who are also qualified immigrants.

     NOTE: Non-citizen veterans and Active Duty Military personnel and their spouses and children are exempt from most of the immigration status related restrictions under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). For example they are eligible for Supplemental Security Income (SSI) and Food Stamps and are exempt from the five year ban.
   - Refugees under Section 207 of the INA (including Amerasian immigrants admitted under the provisions of Public Law 100-202).
   - Victims of a severe form of trafficking are qualified immigrants who receive Medicaid to the same extent as refugees. A comprehensive discussion of this group is set forth at Section "D.4." of this directive.

   Federal Financial Participation (FFP) should be claimed for Medicaid provided to these qualified immigrants.

3. ALL OTHER QUALIFIED IMMIGRANTS WHO ARE NOT IN THE ABOVE TWO GROUPS:

This group of qualified immigrants may receive all care and services available under the Medicaid program, provided s/he is determined to be otherwise eligible. However, for these individuals their Date of Entry (DOE) will determine whether or not Federal Financial Participation (FFP) is available. During their first five years in the U.S. with a status as qualified immigrant, FFP is not available. The cost of their Medicaid coverage will be born solely by State and local shares (50% State/50% local). Once a qualified immigrant in this group has resided in the United States as a qualified immigrant for a period of five years, FFP will become available. This means the federal government will pay a share of their Medicaid costs. The shares are generally split 50%Federal/25%State/25%local.

Therefore, for these individuals it is critical that the Medicaid eligibility worker make the appropriate WMS system changes to assure the change from FNP to FFP claiming as the five year ban period comes to an end.

Qualified immigrants in this group include the following:

- Persons lawfully admitted for permanent residence (i.e. LPRs- "green card holders") under the Immigration and Nationality Act (INA);
- Persons paroled into the United States under Section 212(d)(5) of the INA for a period of at least one year;
- Persons granted conditional entry pursuant to Section 203(a)(7)Immigration and Nationality ACT (INA); and
- Persons who have been determined by the social services district to be in need of Medicaid as a result of being battered or subject to extreme cruelty in the United States by a spouse, parent, or by a member of the spouse's or parent's family residing in the same household as the alien family member at the time of the battering or extreme cruelty. A comprehensive discussion of this group is set forth at Section "D.5." of this directive.

4. VICTIMS OF A SEVERE FORM OF TRAFFICKING:

There have been several new visa categories issued by the United States Citizenship and Immigration Services (USCIS) over the past several years. The T Visa Status is one of them, and is issued by USCIS to immigrants who are "victims of a severe form of trafficking".

For purposes of Medicaid/Family Health Plus/Child Health Plus A eligibility victims of a severe form of trafficking, holders of a T visa/T-1, and holders of T-2, T-3, T-4 and T-5 ("Derivative T-visas") who are the minor children, spouses and in some cases the parents and siblings of victims of severe forms of trafficking in persons, may receive Medicaid benefits to the same extent as refugees (Trafficking Victims Protection Reauthorization Act of 2003 [TVPRA-P.L. 108-193]).

DERIVATIVE T-VISA

For an individual who is already in the United States on the date the derivative T visa is issued, the date of entry is the notice date on the I-797, Notice of Action of Approval (issued by USCIS) for that individual T visa.

For an individual who enters the United States on the basis of a Derivative T visa, the Date of entry is the date stamped on the individual passport or I-94 Arrival Record.

PRIMARY T-VISA HOLDERS

Under the Victims of Trafficking and Violence Protection Act of 2000 (VTVPA), adult victims of trafficking who are certified by the U.S. Department of Health and Human Services (HHS) are eligible for benefits to the same extent as refugees. Children who have been subjected to trafficking are also eligible like refugees but do not need to be certified.

For individuals who meet the criteria, the Office of Refugee Resettlement (ORR) will issue certification letters to victims of trafficking who meet certification requirements. ORR will issue similar letters for children who have been subjected to trafficking. To receive a certification, a victim of trafficking must be willing to assist with the investigation and prosecution of trafficking cases and either

1) have made a bona fide application for a T visa; or
2) be an individual whose continued presence the Attorney General is ensuring to effectuate a trafficking prosecution.

When a victim of trafficking applies for Medicaid benefits, the local district of social services worker must:

1) Accept the certification letter or letter for children in place of USCIS documentation. Victims of severe trafficking do not need to provide any other documentation of their immigration status.

2) Call the trafficking verification line at (202) 401-5510 to confirm the validity of the certification letter or similar letter for children.

3) Note the "entry date" for refugee benefits purposes. The individual's "entry date" for refugee benefits purposes is the certification date, which appears in the body of the certification letter or letter for children. This is the date that must be entered in the WMS system in the Date of Entry (DOE) field.

4) Issue benefits to the same extent as a refugee provided the victim of a severe form of trafficking meets other program eligibility criteria (e.g. income levels).

5) Record the expiration date of the certification letter or letter for children so that re-determinations/renewals of eligibility can be conducted at the appropriate time.

Federal Financial Participation should be claimed for Medicaid provided to these individuals.

5. **BATTERED IMMIGRANTS:**

Battered immigrants filing self-petitions (USCIS Form 1-360: Petition for Amerasian, Widow(er), or Special immigrant) who can establish a "prima facie" case are considered qualified immigrants for the purpose of eligibility for public benefits (Section 501 of the Illegal Immigrant Responsibility and Immigration Reform Act [IIRIRA]). The USCIS reviews each petition initially to determine whether the self-petitioner has addressed each of the requirements listed below and has provided some supporting evidence. This may be in the form of a statement that addresses each requirement. This is called a prima facie determination. When the USCIS makes a prima facie determination, the self-petitioner will receive a Notice of Prima Facie Determination from USCIS.

In order to be a qualified immigrant based on battery or extreme cruelty, the immigrant must not currently be residing in the same household as the individual responsible for the battery or extreme cruelty and must have a petition approved by or pending with the USCIS that sets forth a prima facie case for one of the following statuses:

- Status as a spouse or child of a United States citizen under Sections 204(a)(1)(A)(i), (ii), (iii), or (iv) of the INA;
- Classification to immigrant status as a spouse or child of a lawful permanent resident under Sections 204(a)(1)(B)(i), (ii), (iii), or (iv) of the INA; or
- Suspension of deportation and adjustment to lawful permanent resident status under Section 244(a)(3) of the INA.

A substantial connection between the battery or extreme cruelty suffered by the immigrant (or the immigrant's child or parent) and the need for Medicaid benefits exists under the following circumstances:

- The benefits are needed to enable the immigrant and/or the immigrant's child to become self-sufficient following the separation from the abuser;
- The benefits are needed due to loss of financial support resulting from the immigrant's and/or his/her child's separation from the abuser;
- The benefits are needed because work absence or lower job performance resulting from the battery or extreme cruelty or from legal proceedings relating thereto cause the immigrant to lose his or her job or require the immigrant to leave his/her job for safety reasons;
- The benefits are needed because the immigrant or his/her child requires medical attention or mental health counseling, or has become disabled as a result of the battery or cruelty;
- The benefits are needed to alleviate nutritional risk or need resulting from the abuse or following separation from the abuser;
- The benefits are needed to provide medical care during an unwanted pregnancy resulting from the abuser's sexual assault or abuse of, or relationship with, the immigrant or his/her child, and to care for the resulting children; or

- Medical coverage and/or health care services are needed to replace medical coverage of health care services the immigrant had when living with the abuser.

The federal immigration agency, USCIS, determines whether an immigrant meets the requirements to be a "battered immigrant", as explained above. The worker should refer to Attachment D-1 "Documentation Guide Immigrant Eligibility for Health Coverage in New York State" for the types of USCIS documents these immigrants will have.

E. VERIFICATION OF QUALIFIED IMMIGRANT STATUS

All applicants for Medicaid (except those applying only for the Prenatal Care Assistance Program (PCAP) or the treatment of an emergency medical condition) must provide proof of citizenship or must demonstrate or document "satisfactory immigration status", and verify that status with a United States Citizenship and Immigration Services (USCIS) document. Satisfactory immigration status is an immigration status that does not make the individual ineligible for benefits under the applicable program. Most qualified immigrants will have a "Green Card" (I-551), or an Arrival/Departure Record (I-94) or an Employment Authorization Document (EAD). The following USCIS documents can be used to verify Qualified Immigrant status:

- **Permanent Resident Card USCIS FORM I-151, I-551-"Green Cards":** "Green Cards" (although no longer green in color) are issued to immigrants who have been granted permanent resident status in the United States. They retain this status while in this country. The green card contains two dates, the "Card Expires" date and the "Resident Since" date. The Card Expires date indicates when the card expires and must be renewed. It does **NOT** indicate that the immigrant's status has expired. The immigrant retains his/her status as Lawful Permanent Resident (LPR) while in this country.

  The Resident Since date is the date on which the immigrant acquired lawful resident status. It is not the "date of entry" required for WMS input. The date of entry is not indicated on the green card.

  NOTE: The Date of Entry (DOE) is of particular importance to the eligibility worker because the date will determine whether federal financial participation is available. The worker should record the date of entry in WMS.

  For the purposes of obtaining Medicaid benefits, an I-151 or I-551 that contains an expired date is acceptable documentation of lawful permanent resident status. Although the USCIS requires that the individual simply renew the I-551, this is not a requirement for the purpose of applying for Medicaid.

  No other form of documentation of U.S. residence status is required if an individual has either of these documents.

- **Arrival/Departure Record USCIS FORM I-94:**
  Every immigrant who has been granted permission to enter the U.S. by an Immigration Inspector at an authorized Port of Entry is issued an Arrival/Departure Record, USCIS Form I-94.

  An Arrival/Departure Record will take one of two forms, it can be either:
  - An I-94 stamp in the immigrant's passport (the "I-94" stamp is annotated with the appropriate code); or
  - A white I-94 card, the bottom of which is stapled to a page in the immigrant's passport.

  This document includes the date of entry, how long the person may remain in the U.S. and the terms or codes of admission.

  NOTE: The Date of Entry (DOE) is of particular importance to the eligibility worker because the date will determine whether federal financial participation is available. The worker should record the date of entry in WMS.

  If the only document presented by the applicant is the I-94, the LDSS worker must refer to the desk guide "Key to I-94 Arrival Departure Record" (Attachment D-4 of this directive) to determine if the I-94 code is one that establishes the immigrant status.

  For example: If an individual presents an I-94 card coded "207 or REFUG", the worker would look on the desk guide entitled "Key to I-94 Arrival Departure Record" under the code column for the code "207 or REFUG". The "meaning" column indicates this individual is a Refugee, as illustrated below:

KEY TO I-94 ARRIVAL DEPARTURE RECORD

PERSONS FLEEING PERSECUTION	
CODE	**MEANING**
203(a)(7)	Conditional entrant
207 or REFUG	**Refugee**
208	Asylum
243(h) or 241(b)(3)	Withholding of deportation or removal
AM 1, 2, 3	Amerasian

Next, the worker must refer to the desk guide "Documentation Guide, Immigrant Eligibility for Health Coverage in New York State" (Attachment D-1 of this directive) to determine further the immigrant's status and appropriate Alien/Citizenship Indicator Code (ACI), as illustrated below:

DOCUMENTATION GUIDE: IMMIGRANT ELIGIBILITY FOR HEALTH COVERAGE IN NEW YORK STATE

Category	Documents	WMS ACI code
Refugees	**►I-94 or passport with annotation "Section 207" or "refugee" ►I-551 coded R8-6, RE6, RE7, RE8, or RE9 ►I-571 Refugee Travel Document ►I-688B or I-766 coded 274a.12(a)(3) or A3**	**R**

- **Employment Authorization Documents (EAC and EAD) USCIS FORMS I-688B, I-766:**
  If the USCIS permits an immigrant to work legally in the U.S., an Employment Authorization Document or Card (EAD or EAC) will be issued. Permanent residents, PRUCOLs and individuals waiting for an adjustment of status can all apply for and may be issued such documents.

  An Employment Authorization Document (EAD) Form I-688B is issued to immigrants who are not permanent residents but have been granted permission to be employed in the U.S. for a specific period of time. (This may include foreign students, visitors on business or pleasure and certain other visa holders).

  An Employment Authorization Card (EAC) Form I-766 is a newer version similar to a credit card document. Both the I-688B and the I-766 have a "category" section that indicates the immigration status code when issued.

  The status code indicated in the category section of the EAD or EAC must be checked on the desk guide Attachment D-3 "Key to I-766, I-688B, Employment Authorization Documents (EADs)" to determine the individual's immigration status and type of health benefit they may be eligible for.

  Because an EAD/EAC can be issued to non-immigrants it can not stand alone. Therefore, an eligibility worker must look at additional documentation to establish immigrant status.

  An expired EAD or EAC alone is **not** acceptable proof of immigration status because these forms may be issued to nonimmigrants. If used, an expired EAD or EAC must be accompanied by other supporting USCIS document(s).

F. PERSONS PERMANENTLY RESIDING UNDER COLOR OF LAW (PRUCOL)

Persons permanently residing in the United States under color of law (PRUCOL) are eligible for Medicaid, Family Health Plus (FHPlus) and Child Health Plus A (CHPlus A) provided they meet all other eligibility requirements. There is **no** Federal Financial Participation for this group. This means the federal government will not pay a share of their Medicaid costs. The shares are generally split
50% State/50% local.

Immigrants who are PRUCOL for Medicaid eligibility purposes are any persons who are permanently residing in the United States with the **knowledge and permission or acquiescence** of the United States Citizenship and Immigration Services (USCIS) and whose departure from the United States the USCIS does not contemplate enforcing.

An immigrant is considered as one whose departure the USCIS does not contemplate enforcing if, based on all the facts and circumstances of the particular case, it appears that the USCIS is otherwise permitting the immigrant to reside in the United States indefinitely or it is the policy or practice of the USCIS not to enforce the departure of immigrants in a particular category.

Prior to August 22, 1996, immigrants who were considered PRUCOL were eligible for a number of federal programs, including Medicaid, SSI, and Aid to Families with Dependent Children (AFDC). The term is now used for Unemployment Insurance purposes and also by a number of States in determining eligibility for state funded programs such as FNP Medicaid. The term also has been defined in decisions of federal and state courts, and the number and types of statuses that may be considered PRUCOL vary from state to state, benefit program to benefit program.

There are several categories of PRUCOL immigrants. These categories are listed below and are also set forth in several attachments to this directive including Attachments B-1, B-2, entitled "Documentation Guide for PRUCOL Alien Categories," and D-1, entitled "Documentation Guide Immigrant Eligibility for Health Coverage in New York State."

All immigrants who establish their status as PRUCOL under any of these categories are eligible for Medicaid, Family Health Plus and Child Health Plus A, provided they meet such programs' other eligibility requirements.

In New York State, for the purposes of Medicaid eligibility, the following statuses are considered PRUCOL:

a) Persons paroled into the U.S. pursuant to Section 212(d)(5) of the INA showing status for less than one year, except Cuban/Haitian entrants;
b) Persons residing in the U.S. pursuant to an Order of Supervision;
c) Persons residing in the U.S. pursuant to an indefinite stay of deportation;

d) Persons residing in the U.S. pursuant to an indefinite voluntary departure;
e) Persons on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure, but whose departure the USCIS does not contemplate enforcing;
f) Persons who have filed applications for adjustment of status pursuant to Section 245 of the INA that USCIS considers "properly filed" or granted and whose departure the USCIS does not contemplate enforcing;
g) Persons granted stays of deportation by court order, statute, or regulation, or individual determination by USCIS pursuant to Section 243 of the INA and whose departure the USCIS does not contemplate enforcing;
h) Persons granted voluntary departure pursuant to Section 242 (b) of the INA;
i) Persons granted deferred action status pursuant to USCIS operating instructions;
j) Persons who entered and have continuously resided in the U.S. since before 1/01/72;
k) Persons granted suspension of deportation pursuant to Section 244 of the INA; USCIS does not contemplate enforcing the departure; and
l) Other persons living in the United States with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing. Examples include but are not limited to, the following:
    - Permanent non-immigrants pursuant to Public Law 99-239 (applicable to Citizens of the Federated States of Micronesia and Marshall Islands);
    - Applicants for adjustment of status, asylum, suspension of deportation or cancellation of removal, or deferred action;
    - Persons granted extended voluntary departure, or Deferred Enforced Departure (DED) for a specified time due to conditions in their home country;
    - Persons granted Temporary Protected Status; and
    - Persons having a "K", "V", "S" or "U" visa.

G. VERIFICATION OF PRUCOL STATUS

The Medicaid eligibility worker must understand that the USCIS does not determine whether an immigrant is PRUCOL. To the contrary, the eligibility worker must determine whether the immigrant is PRUCOL by reviewing the documentation and other information that the immigrant presents to establish that he or she is PRUCOL.

To be PRUCOL, the immigrant must possess or obtain documentation that establishes that he or she is permanently residing in the United States with either of the following:

- the knowledge and permission of the USCIS; **or**
- the knowledge and acquiescence of the USCIS.

These concepts are important and are explained further, below.

Permanently residing in the U.S. with the knowledge and permission of the USCIS:

This means that the USCIS "knows" that the immigrant is present in the U.S. and has granted its permission for the immigrant to remain in this country, at least for the time-being; that is, the USCIS is not contemplating enforcing the immigrant's departure at this time. As a general rule, immigrants will be permanently residing in the U.S. with the knowledge and permission of the USCIS when the USCIS has granted the immigrant a particular immigration status. The immigrant will have a document or form issued by the USCIS that indicates the particular immigration status that the USCIS has granted. The USCIS provides different documents and forms to immigrants, depending upon that immigrant's specific immigration status. In some cases, an immigrant may also have a document issued by an immigration court that permits the immigrant to remain in this country.

Permanently residing in the U.S. with the knowledge and acquiescence of the USCIS:

This means that the USCIS "knows or can reasonably be expected to know" that the immigrant is present in the U.S. and, although the USCIS may not have officially granted the immigrant permission to remain in this country, as demonstrated by a particular USCIS document or form granting a particular immigration status, the USCIS, through its silence or inaction, is apparently acquiescing in the immigrant's presence here, at least for the time-being. These immigrants will not have any USCIS document or form establishing that the USCIS has granted them a particular immigration status. However, the immigrant can be expected to present documentation of his or her contacts with the USCIS. This documentation must be sufficient to establish that the USCIS has knowledge of the immigrant's presence in the U.S. or, given all the facts and circumstances of the particular case, one may reasonably conclude that the USCIS knows that the immigrant is here. For example, the immigrant may have a copy of his or her letter to the USCIS applying for a particular immigration status and documentation, such as a return receipt for certified mail, showing that the USCIS would have received this letter. The USCIS's acquiescence in the immigrant's presence in the U.S. may be established when the USCIS, despite having been notified of the immigrant's presence in this country, fails after a reasonable period of time to respond to the immigrant's letters or fails to take any action to enforce the immigrant's departure from the U.S.

Both of these concepts are explained below, with specific reference to the PRUCOL categories listed at pages 19 and 20 of this directive. For most of these PRUCOL categories, the USCIS will have issued the immigrant a document or form showing that the USCIS has granted the immigrant a particular immigration status. As noted, however, immigrants may be found to be PRUCOL even in the absence of a USCIS document or form granting an immigration status.

1. VERIFICATION OF PRUCOL STATUS FOR IMMIGRANTS TO WHOM THE USCIS HAS ISSUED DOCUMENTS OR FORMS GRANTING AN IMMIGRATION STATUS:

a. Immigrants to whom PRUCOL categories (a)-(k) apply:

When an eligibility worker verifies immigration documents for PRUCOL categories "a" through "k", documentation is fairly straight forward. By referring to the desk guide "DOCUMENTATION GUIDE FOR PRUCOL ALIEN CATEGORIES" (Attachment B-2 of this directive and/or Desk Guide Attachment D-1: "Category 3") the worker needs only to match the appropriate document presented to the category of PRUCOL "a through k".

For example: When an individual presents an I-797 Notice of Action indicating an I-130 Petition for Alien Relative has been approved, the worker would review page 5 of the desk guide "Documentation Guide, Immigrant Eligibility for Health Coverage in New York State" (Attachment D-1 of this directive) to determine the type of USCIS document the worker is reviewing.

Reproduced below is the relevant portion of page 5 of the desk guide highlighting the I-797 and I-130:

U. S. Citizenship and Immigration Services (USCIS) Documents

I-94	**Arrival Departure Card**	I-571	**Refugee Travel Document**
I-181	**Memorandum Of Creation of Record of Lawful Permanent Residence**	I-688	**Temporary Resident Card**
I-210	**Voluntary Departure**	I-688A	**Employment Authorization For Legalization Applicants**
I-220B	**Order of Supervision**	I-688B	**Employment Authorization Card**
I-130	**Petition for Alien Relative**	I-766	**Employment Authorization Card**
I-140	**Immigrant Petition for Alien Worker**	I-797	**Notice of Action (I-797C current version)**
I-327	**Reentry Permit for permanent residents**	DD-Form 2	**Military Identification Card**
I-551	**Legal Permanent Resident Card, Resident Alien Card or "green card"**	DD-214	**Report of Separation Military Discharge Document**

Next, the worker would turn to page 3 of the desk guide "Documentation Guide Immigrant Eligibility for Health Coverage in New York State" (Attachment D-1 of this directive)under "Category 3: Persons who are Permanently Residing under Color of Law (PRUCOL)". The worker can then identify the category of PRUCOL by matching the documentation to the category. In this particular example, the worker would conclude that the appropriate PRUCOL category is (e), "Persons on whose behalf an immediate relative petition has been approved and his or her families covered by one petition", as illustrated below:

Category 3: Persons who are Permanently Residing Under Color of Law (PRUCOL)*

Category	Documentation	WMS ACI code
e. Persons on whose behalf an immediate relative petition has been approved and her/his families covered by the petition ***(Non-citizens who are immediate relatives (spouse, father, mother, or unmarried child under 21) of a U.S. citizen/LPR who has filed an I-130 on their behalf.)***	**►I-94 and/or I-210 indicating departure on a specified date, however, the USCIS expects the non-citizen's visa will be available within this time** **►I-797 indicating I-130 petition has been approved** **►Also see documentation listed under category "I"**	O

b. <u>Immigrants granted a "K," "V," "S" or "U" visa</u>:

There have been several new visa categories issued by the United States Citizenship and Immigration Services (USCIS) over the past several years.

Some categories of "special" nonimmigrant statuses allow the status (visa) holder to work and eventually adjust to lawful permanent residence. These categories allow the individual to apply for adjustment to LPR status after he or she has had the non-immigrant status for a period of time. These statuses are included in the category defined as: "Other persons living in the U.S. with the knowledge and permission or acquiescence of USCIS and whose departure USCIS does not contemplate enforcing."

Such statuses include, for example:

K status: For the spouse, child, or fiancé(e) of a U.S. citizen.

S status: For informants providing evidence for a criminal investigation. Also known as the "Snitch Visa".

U status: For victims or witnesses of specified crimes (who have suffered substantial physical or mental abuse and agrees to cooperate with the government).

V status: For spouses and children of LPR's whose visa petitions (Form I-130) have been pending for at least three years.

NOTE: THE ABOVE USCIS VISA CATERGORIES ARE NOT TO BE CONFUSED WITH WMS ALIEN CITIZENSHIP INDICATOR CODES (ACI CODES).

If otherwise eligible, an individual with a visa category of K or V or S or U should be authorized for Medicaid, FHPlus and CHPlus A as PRUCOL. These visa categories are discussed further, below:

The K and V Visa Status

Nonimmigrant visas V (Visa codes V-1, V-2 and V-3) and K (Visa codes K-3 and K-4) are two new categories of "special" nonimmigrant visas that were created by the Legal Immigration and Family Equity Act (LIFE Act) and are issued to persons intending to live permanently in the United States. The V visa may be issued to alien spouses and minor children of lawful permanent residents whose family petitions (the I-130) have been pending for some time. The V visa is intended to permit family reunification while the immigration cases of the lawful permanent resident's spouse and children are pending. The K visa allows alien spouses and minor children of United States citizens to enter the United States legally and obtain work authorization. Individuals issued any of these visas may enter the United States as nonimmigrants to complete the immigration process.

The S and U Visa Status

Holders of the S (Visa codes S-5, S-6 and S-7) or U visas (Visa codes U-1, U-2, U-3, and U-4) are considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus A.

The S visa status is given to aliens who assist U.S. law enforcement to investigate and prosecute crimes and terrorist activities. S visa holders are allowed to adjust status to permanent resident under Section 245(j) of the Immigration and Nationality Act.

The U visa status is given to aliens who are victims and/or witnesses of certain crimes who are assisting an investigation or prosecution. This status allows the nonimmigrant to remain in the U.S. and to work. After three years in this status, a U status holder can apply to adjust their status.

With respect to the U visa status, the USCIS has directed that individuals who satisfactorily demonstrate to USCIS that they are eligible for a U visa are to be granted Deferred Action status. As such, holders of U visas are to be considered PRUCOL and, if otherwise eligible, may receive Medicaid, FHPlus or CHPlus A.

c. Immigrants granted temporary protected status:

- These immigrants are treated as PRUCOL for purposes of their eligibility for Medicaid, FHP or CHPlus A. "Temporary protected status" is a temporary immigration status granted under federal law at 8 U.S.C. 1254a to immigrants who are physically present in the United States and who are from certain countries designated by the U.S. Attorney General as unsafe to accept their return because of ongoing environmental disasters or other extraordinary and temporary conditions. Currently, the following countries have TPS designation Angola, Burundi, El Salvador, Honduras, Liberia, Montserrat, Nicaragua, Sierra Leone, Somalia, and Sudan. [A list

of countries designated for TPS is located at the United States Citizenship and Immigration Services' (USCIS) (formerly the Immigration and Naturalization Service-INS) website, at http://uscis.gov].

Persons granted TPS are authorized to remain in the United States for a specific limited period; the U.S. Attorney General can extend it for a further specified period. Prior to 1990, a similar status called "Extended Voluntary Departure" was used in the same way to provide relief to particular nationalities.

Persons granted temporary protected status will have one of the following types of documentation:

- Form I-688B; or
- Form I-766 EAD coded 274a.12(a)(12) or A12; or
- A letter, verification or correspondence from USCIS, such as a Notice of Action (I-797) indicating temporary protected status has been granted.

- Applicants who have applied for Temporary Protected Status (TPS): These immigrants are treated as PRUCOL for purposes of their eligibility for Medicaid, Family Health Plus or Child Health Plus A if it reasonably appears, based on all the facts and circumstances of the case, that they are present in the United States with the **knowledge** and **permission** or the **acquiescence** of the federal immigration agency and that such agency is not presently contemplating deporting them. Social Services districts should request proof from the immigrant that he or she filed the Application for Temporary Protected Status (Form I-821) and the Application for Employment Authorization (Form I-765) to the USCIS or its predecessor, the INS. For example, the immigrant may have a receipt or letter from the federal immigration agency that shows that such agency received these documents. However, the immigrant does not need to have written confirmation from the federal immigration agency acknowledging its receipt of these documents. An immigrant can be considered PRUCOL if the immigrant can prove that he or she mailed these documents to the federal immigration agency on a certain date. When the federal immigration agency has not acted on the application after a reasonable period of time after mailing, the district may reasonably presume that the applicant is PRUCOL. Applicants for temporary protected status will have one of the following types of documentation:
  - Receipt or notice showing filing of Form I-821 (Application for Temporary Protected Status) and Form I-765 (Application for Employment Authorization); or
  - Form I-688B; or
  - Form I-766 EAD coded 274a.12(c)(19) or C19; or
  - Any letter, verification or correspondence from USCIS or a U.S. Postal Return Receipt.

2. VERIFICATION OF PRUCOL STATUS FOR OTHER IMMIGRANTS, INCLUDING APPLICANTS FOR A PARTICULAR IMMIGRATION STATUS:

An immigrant can be PRUCOL even if the USCIS has not granted him or her a particular immigration status. Typically, these immigrants have applied to the USCIS for a particular immigration status or for work authorization. These immigrants will not necessarily have a document or form issued by the USCIS that officially grants them a particular immigration status. Nonetheless, they can be PRUCOL when they establish that they are permanently residing in the U.S. with the knowledge and permission or acquiescence of the USCIS. These PRUCOL immigrants are included among the immigrants in PRUCOL category "l": that is, "other persons living in the United States with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing."

Determining whether an immigrant is present in the U.S. with the knowledge and acquiescence of the USCIS.

The particular facts and circumstances of each immigrant's case establishes whether the USCIS has "knowledge" of the immigrant's presence in the U.S. and whether the USCIS can be seen as acquiescing in, or accepting, the immigrant's presence, at least for the time-being. Both of these elements must be established for the immigrant to be PRUCOL under this category.

To determine whether an immigrant is within this PRUCOL category, the eligibility worker must look for the following:

a. Establishing that the USCIS has "knowledge" of the immigrant's presence:

Any correspondence that the immigrant has received from the USCIS will establish that the USCIS has knowledge of the immigrant's presence in the United States. Such correspondence may include, but is not limited to, any of the following:

- USCIS receipt notice;
- "Notice of Action" issued by USCIS;
- USCIS fee receipt; or
- Cancelled check for payment of a USCIS fee.

Each of these documents proves that the USCIS has received a form or other request for change in status or issuance of a work authorization. As proof of correspondence with the USCIS, the eligibility worker may also accept a copy of a letter that the immigrant has sent to the USCIS together with documentation, such as a U.S. Postal Service Return Receipt form, showing that the USCIS actually received such letter. A letter to the USCIS, without verification that USCIS actually received the letter, is not sufficient documentation to support PRUCOL status.

b. Establishing that the USCIS is acquiescing in the immigrant's presence in the U.S.:

It is important for the eligibility worker to understand that there are two ways to establish that the USCIS is acquiescing in the immigrant's presence in the U.S. First, the immigrant may have a document from the USCIS that demonstrates acquiescence. For example, the immigrant may have a document from the USCIS in which the USCIS advises the immigrant that it is reviewing the immigrant's application for a change in status. Acquiescence can be demonstrated, however, even if the immigrant has no documentation from the USCIS but, rather, the USCIS has failed to respond to the immigrant's correspondence within a reasonable period of time. For example, the worker may determine that the USCIS is acquiescing in the immigrant's presence in the U.S. when the immigrant has applied to the USCIS for a change in status, presents documentation (such as a return receipt form) establishing that the USCIS has received an application but has failed to respond within a reasonable period of time or has failed to take any action to enforce the immigrant's departure.

A few examples illustrate how the eligibility worker may determine whether the immigrant is PRUCOL because he or she is permanently residing in the U.S. with the **knowledge** and **permission** or **acquiescence** of the USCIS even if the immigrant does not have a document or other form from the USCIS that grants the immigrant a particular immigration status:

Example 1: An immigrant has written to the USCIS to request a change in his immigration status. He has completed the appropriate USCIS application form. He has a U.S. Postal Service Return Receipt indicating that the USCIS received his letter. Alternatively, he might have a USCIS receipt that verifies the fee for filing the form was paid. In addition, he may have a Notice of Action (I-797) from the USCIS stating that his application was received and is being reviewed. All of this documentation shows the Medicaid eligibility worker that the USCIS knows the individual is present in the U.S. and is acquiescing in his or her presence, at least for the time-being.

Example 2: Same fact pattern as above, but the USCIS has failed to respond in any way to the immigrant's letter after having a reasonable time in which to respond. In this case, the immigrant has established that the USCIS knows he is present in this country. The USCIS's acquiescence may be inferred by the USCIS's silence; that is, its failure to respond in any way to the immigrant's letter after having been afforded a reasonable period of time in which to do so.

H. GENERAL DOCUMENTATION REQUIREMENTS

1. SOCIAL SECURITY NUMBERS

Effective April 1, 2003, applicants for Medicaid, Child Health Plus A and Family Health Plus who are required to provide a Social Security Number (SSN) or proof of application for a SSN must continue to do so, but are no longer required to document the SSN. This means that applicants are required to tell the district what

their SSN is, but they are not required to show proof of the SSN initially. The only time documentation is necessary is if the SSN cannot be verified or validated through the Welfare Management System (WMS) SSN Validation process (GIS 03 MA/008). Documentation of application for SSN continues to be required when appropriate. Districts must continue to confirm that the SSN provided is correct.

Some immigrants may not have a SSN. The Social Security Administration (SSA) may issue Social Security Numbers (SSN) to immigrants if State Law requires a SSN as a condition of eligibility for Public Benefits. New York State's laws and regulations require a Social Security Number for public benefits, including Medicaid [Social Services Law Section 134-a(2), 18 NYCRR Sections 351.2(c), 360-1.2]. All applicants for Medicaid thus must provide a Social Security Number or proof that they have applied for one or tried to apply for one. The only exceptions are pregnant women, undocumented immigrants and temporary non-immigrants applying for the treatment of an emergency medical condition and certain battered women immigrants who prove their status under the Violence Against Women ACT (VAWA), as set forth in the section titled "Battered Immigrant" of this directive.

A Medicaid eligibility worker should try to help the immigrant apply for a SSN. The worker should refer the applicant to a local Social Security office and provide the applicant with a letter on agency letterhead requesting a Social Security Number be issued. A sample letter "Agency Letter Request for Social Security Number" is attached to this directive as Attachment A-1.

If an applicant still cannot get a SSN, then the applicant can submit a statement to the Medicaid eligibility worker describing how s/he tried to get an SSN. A sample "Social Security Number Attestation Form" is attached to this directive as Attachment A-2.

A Medicaid application **cannot be delayed or denied** if the immigrant does not have a SSN or cannot get "proof" from the Social Security Administration that they tried to apply. If the applicant makes no attempt to supply a SSN or a statement attesting to the applicant's efforts to apply for a SSN, the application can be denied.

2. LOST AND/OR EXPIRED DOCUMENTS

Immigrants' eligibility for benefits is based on the immigration status they receive from the United States Citizenship and Immigration Services (USCIS). Immigrants are required by law to carry immigration documents as evidence of their status.

Generally, expired USCIS documents cannot be used to establish an immigrant's status. The only exception is an expired I-151 or I-551 "Green Card". That is because the expiration date on a "Green Card" is only an indicator of when the card must be renewed. It is not an indication that the immigrant's status has expired. Lawful Permanent Resident status does not have an expiration date.

Any other expired USCIS document an immigrant may present can not stand alone to establish the immigrant's status. A Medicaid eligibility worker must see other supporting USCIS documentation to properly determine the immigrant's status.

When an immigrant applicant has only expired USCIS documentation or claims a lawful immigration status, but has lost his/her immigration documentation, local districts should follow the appropriate procedure outlined below:

- **Lost Immigration Documentation**

Immigrants claiming a lawful immigration status and who have lost their immigration documentation should be referred to the USCIS for replacement documentation. Local districts need some verification from USCIS of an immigrant's lawful presence in order to make a determination of the immigrant's eligibility for benefits.

- **Expired Immigration Documentation**

a.) Permanent Resident Card

The most common USCIS document used to prove lawful permanent resident status (LPR) is the Permanent Resident Card (I-551). Commonly called the "Green Card", an I-551 expires after 10 years. USCIS began implementing a 10-year expiration period in 1989 to allow the agency to update photo identification and implement new card technologies that will increase the card's resistance to counterfeiting and tampering. Immigrants do not lose permanent resident status because their Green Card has expired. However, they are required by law to carry evidence of their immigration status, such as a valid Green Card or some other temporary proof of status provided by USCIS, while a Green Card renewal is being processed.

If the only immigration document an immigrant has is an expired Green Card, local districts can use it to determine the immigrant's eligibility for benefits.

Many immigrants do not renew their Green Cards because of the processing fee. A fee is imposed because federal guidelines require the processing of immigration benefits to be self-supported by filing fees.

USCIS does have discretion to waive any fee, if the applicant establishes that he/she is unable to pay the fee. Information on how an applicant can apply for a fee waiver is found on the USCIS Web site at: http://uscis.gov

b.) Foreign Passport with a Form I-551 Stamp

It often takes many months for immigrants to actually receive their Green Cards. While they are waiting for their card, USCIS can provide temporary evidence of permanent residence by stamping an immigrant's passport with an I-551 stamp. Immigrants' passports can also have an I-551 stamp for Green Card renewals. If the I-551 stamp has expired and the immigrant has no other immigration documents, districts can use the expired I-551 stamp to determine an immigrant's eligibility for benefits.

c.) Form I-94 Arrival/Departure Record

The I-94 record is created by USCIS when an immigrant is inspected upon arrival in the United States. The I-94 is a 3" X 5" card that the inspector endorses with the date, place of arrival and the class of admission. The card is stamped or handwritten with a notation that indicates the immigration category or the section of immigration law under which the person is granted admission. The words "Employment Authorized" may also be stamped on the card. Only immigrants with an Arrival/Departure Record (I-94) that has specific satisfactory immigration status notations would be eligible for benefits. Districts need to carefully note the admitting status on the I-94 and use the Desk Guide "KEY to I-94 Arrival Departure Record" (Attachment D-4) to determine an immigrant's eligibility for benefits.

d.) Form I-668B or I-766 Employment Authorization Documents (EAD)

These documents indicate that an immigrant or non-immigrant is authorized to work in the U.S. Many qualified immigrants are not automatically authorized to work in the U.S. by virtue of their immigration status. Both these forms indicate an individual's immigration status. If the only documentation an immigrant has is an expired EAD, districts may use it to determine the immigrant's eligibility for benefits. EADs are also issued to temporary residents who are non-immigrants and are eligible only for the treatment of an emergency medical condition. The immigrant's immigration status on the EAD must be checked against USCIS immigration statuses on the Desk Guide "Key to I-766, I-688B Employment Authorization Document (EAD)" (Attachment D-3) to determine benefits for which the immigrant may be eligible.

Any time a district must use expired immigration documents for a determination of an immigrant's eligibility the district needs to:

- Verify the immigrant's status by sending a G-845 (Documentation Verification Request) to USCIS. The form and instructions for filing may be downloaded from the USCIS web site at http://uscis.gov. Go to "Forms and Fees" or by following the procedures in 1999-LCM-23 (Implementation of the Systematic Alien Verification for Entitlements (SAVE)-Interim Process). http://sdssnet5/otda/directives/1999/LCM/99LCM-23.pdf
- Advise the immigrant that s/he needs to go to USCIS to renew his/her Green Card or other immigration documentation.
- Use the immigration status on the expired immigration documentation as the basis for the immigrant's eligibility. Districts should refer to the attached Desk Guides: Attachments B-1, B-2, D1, D2, D-3 and D-4.

I. ELIGIBILITY OF IMMIGRANTS FOR MEDICAID COVERAGE FOR THE TREATMENT OF AN EMERGENCY MEDICAL CONDITION

1. UNDOCUMENTED IMMIGRANTS

An immigrant who is not a qualified immigrant and not PRUCOL (hereafter referred to as undocumented) is not eligible to receive medical care or services under the Medicaid program unless the immigrant is otherwise eligible and the care and services are necessary for the treatment of an emergency medical condition.

NOTE: Undocumented immigrant does not include PRUCOL category "l" in which the immigrant has contacted the USCIS and may or may not have substantial/official documentation.

Undocumented immigrants are unable to provide documentation of immigration status; therefore, absent any documentation they are eligible only for the treatment of an emergency medical condition.

2. TEMPORARY NONIMMIGRANTS

Some immigrants may be lawfully admitted to the United States, but only for a temporary or specified period of time, as legal nonimmigrants. These immigrants are not eligible for Medicaid because of the temporary nature of their admission status. These immigrants are never qualified immigrants, but in some cases may meet the state residence rules. If this is the case, such nonimmigrants could be determined eligible for Medicaid for the treatment of an emergency medical condition, if otherwise eligible, provided they did not enter the state for the purpose of obtaining medical care.

A visa is issued to persons with permanent residence outside the U.S. but who are in the U.S. on a temporary basis, for example: tourism, medical treatment, business, temporary work or study. Districts are reminded that because of the temporary nature of their admission status, these nonimmigrants, although lawfully admitted to the United States, are eligible for Medical Assistance care and services only for the treatment of an emergency medical condition. (See attached Desk Guide Attachment D-1, Category 4: "NONIMMIGRANTS".)

Most nonimmigrants can be accompanied or joined by spouses and unmarried minor (or dependent children).

The following categories of individuals are examples of temporary legal nonimmigrants and their visa category:

NOTE: THESE USCIS VISA CATERGORIES ARE NOT TO BE CONFUSED WITH WMS ALIEN CITIZENSHIP INDICATOR CODES (ACI CODES).

- A Visa: Foreign government officials
- B-1, B-2 Visa: Temporary Business/pleasure Visitors
- C Visa: Aliens in transit through the United States
- D-1 Visa: Crewmen
- E-1, E-2 Visa: Treaty Traders and Investors
- F Visa: Students (including spouses and children)*
- G Visa: International Representatives
- H-1B Visa: Skilled Professionals, Temporary Workers
- I Visa: Representatives of foreign information media
- J-1 Visa: Practical Trainees, Exchange Visitors
- L Visa: Intra-company Transferees
- NATO Visa: NATO officials
- *TN Visa-Canada: Canadian Professionals and Consultants*
- *TN Visa-Mexico: Mexican Professionals and Consultants*
- O Visa: Temporary Workers with Extraordinary Abilities
- P Visa: Athletes, artists and entertainers (including spouses and children)
- Q Visa: Participants in international cultural exchange programs
- R-1, R-2 Visa: Temporary workers performing work in religious occupations (including spouses and children)

These immigrants have the following types of USCIS documentation:

- Form I-94 Arrival-Departure Record (contains the visa category code and Date of Entry);
- Form I-185 Canadian Border Crossing Card (BCC)*;
- Form I-186 Mexican Border Crossing Card (BCC)*;
- Form SW-434 Mexican Border Visitor's Permit*; or
- Form I-95A Crewman's Landing Permit.

*B-1/B-2 Visa/BCC is now issued in place of these documents.

TREATMENT OF AN EMERGENCY MEDICAL CONDITION

To be eligible for treatment of an emergency medical condition, an undocumented immigrant or a temporary nonimmigrant must meet all eligibility requirements, including state residence.

An "**emergency medical condition**" is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

-placing the person's health in serious jeopardy;
-serious impairment to bodily functions; or
-serious dysfunction of any bodily organ or part.

Treatment of emergency medical conditions does not include care and services related to an organ transplant procedure.

Federal regulations at 42 CFR 440.255 provide that federal reimbursement is available after the sudden onset of the medical condition. Certain types of care provided to chronically ill persons are beyond the intent of federal law and are not considered emergency services. Such care includes alternate level of care (including private duty nursing) and personal care.

Temporary nonimmigrants and undocumented immigrants applying for coverage for the treatment of emergency medical conditions must submit the LDSS-3955 (Upstate) or MAP 2151 (NYC): "Certification of Treatment of Emergency Medical Condition," completed and signed by a physician. The DSS-3955 has been revised is attached to this directive as Attachment E-1. Social Service districts must begin using the revised LDSS-3955 immediately. Social services districts must discard any existing supplies of the previous version of the LDSS-3955.

Because the care that can be covered by Medicaid under the definition of emergency medical condition is limited, authorizations for emergency care **must** cover a specific period of time in the past. The social services district must notify the provider of the acceptance/denial of the application, the period of coverage and the individual's Client Identification Number (CIN) when appropriate.

A new DSS-3955 or MAP 2151 must be obtained from a physician at least once every 90 days, in order to continue the Medicaid authorization.

V. SYSTEMS IMPLICATIONS

Upstate Systems Implications

Over the past few years, various systems changes have been implemented to support the Department's policy pursuant to the Aliessa decision. The purpose of this section is to reiterate existing system support for these immigrants.

WMS utilizes a series of Alien/Citizenship Indicator Codes (ACI) to identify citizens, qualified and PRUCOL immigrants, and those immigrants eligible for the treatment of an emergency medical condition.

The following is a listing of the Alien/Citizenship Codes currently supported by WMS:

CITIZENSHIP/ALIEN INDICATOR CODES

A Person Granted Asylum
B Battered Alien
C Citizen
D Trafficking Victims (Upstate)
E Alien Only Eligible for Emergency
F Person Granted Conditional Entry
G Person Paroled into the U.S. for at Least 1 Year
H Cuban and Haitian Entrant
J Person whose Deportation is being withheld
K Lawful Permanent Resident W/O 40 Quarters or 40 Quarters Not Determined
M Qualified immigrant on Active Duty in Armed Forces (inc. Spouse & Dependent Child)
N PRUCOL Alien Diagnosed with AIDS or Residing in RHCF on 8/4/97
O PRUCOL Eligible for MA/FHP/CHPA/SN/FAP
R Person Admitted as Refugee/Amerasian (includes Victims of Trafficking-NYC)
S Lawful Permanent Resident with 40 Qualifying Quarters
T Person Paroled into the U.S. for less than One Year
V Veteran of the Armed Forces (including the Spouse & Dependent Child)

NOTE: THE ABOVE WMS ALIEN CITIZENSHIP INDICATOR CODES (ACI CODES) ARE NOT TO BE CONFUSED WITH USCIS VISA CATEGORIES.

In addition to the ACI, the proper Recipient Coverage Code and/or State/Federal Charge Code should be entered, as described below, to assure that the proper Federal/State/Local shares are derived.

Specifically; for individuals in the five year federal ban, the following system support exists:

1. For fully eligible, fee for service (non-Managed Care) individuals, Recipient Coverage Code 11 (Legal Alien - Full Coverage) is now generated for Case Types 11, 12, 16, 17, and 20. This Coverage Code produces an Aid Category Value of 76 (Legal Alien - FNP). This Aid Category assures that non-emergency Medicaid claims are reimbursed at 50% State/50% Local share.
   - Entry, or generation, (if Blank) of the Coverage Code 11 is allowed for ACI of B, F, G, K, S or T when the Date of Entry is greater than or equal to 9/96 and the MA coverage "from" date is less than five years from the Date of Entry (DOE).
   - When the ACI is N or O, Coverage Code 11 is entered or system generated. ACI codes N or O are always FNP regardless of the Date of Entry.

2. For Managed Care (including Family Health Plus) or spenddown cases, the appropriate Managed Care, FHP, or spenddown Coverage Code should be entered. Entry of a Coverage Code 11 is valid for entry into the PCP subsystem. Following storage of the PCP enrollment, the proper PCP Coverage Code will be generated based upon the recipient's Categorical Code. It is important to data enter the State/Federal Charge Code of 60 or 67 so that when the Coverage Code is changed, proper State and Local claiming is achieved (Details in GIS 02 MA/002 and 01 MA/030).

   Specifically:

   a. State/Federal Charge Code 60 (TANF Ineligible Alien) should be entered on any case type.
      - State/Federal Charge Code 60 is required for individuals with a Citizenship Indicator of B, F, or K and a Date of Entry greater than or equal to 9/96 and an MA From Date less than five years from the Date of Entry.

   b. State/Federal Charge Code 67 (State Charge - Qualified Alien in the five year ban for Medicaid/PRUCOL) should be entered for MA Only (Case Type 20), Family Health Plus (Case Type 24) and Cash Assistance (Case Types 11, 12, 16, 17) cases.
      - State/Federal Charge Code 67 is also required when the ACI is G, S, or T and the Date of Entry is greater that or equal to 9/96 and the MA From Date is less than five years from the Date of Entry.
      - State/Federal Charge Code 67 is also required for an ACI of O. Since O does not require a Date of Entry, 67 is required regardless of the Date of Entry, including a BLANK.

3. Anticipated Future Action (AFA) Code 522 (Expiration of MA 5 Year ban) will appear on WMS Report, WINR 4137- Undercare-Notice of Anticipated Future Action, when the federal 5 year ban is due to expire. The 522 AFA Code can be data entered or is system generated 4 years, 11 months after the Date of Entry. The worker should then remove the State/Federal Charge Code from WMS.

4. Emergency Medical Assistance is provided to illegal or undocumented immigrants and temporary nonimmigrants who are in need of care due to an emergency medical condition and are otherwise eligible. In order to properly pay for these services, the ACI for these individuals must be "E" (Aliens Only Eligible for Emergency MA). In addition, the Recipient Medicaid Coverage Code on Screen 5 should be "07" (Emergency Services Only). The Medicaid Coverage From and To Dates should reflect the actual duration of the emergency condition and must be date specific. When a claim is received from an enrolled provider indicating it is for the treatment of an Emergency, the claim will be paid with federal participation (50% Federal/25% State/25% local).

NYC Systems Implications

New York City WMS instructions have been issued separately.

NOTICE REQUIREMENTS

As of November 2004, with the implementation of CNS Acceptance Notices (upstate) for the treatment of an emergency medical condition, Manual Notice Form 3622 will be revised deleting all references to emergency medical care.

Manual Notice Form 36622A is rescinded.

Social services districts must discard any existing supplies of the previous version of the manual notice 3622A.

CNS Notices of Acceptance (Upstate) for the treatment of an emergency medical condition, including spenddown cases have been developed:

	Reason Code	Paragraph #	Description
•	S77	Y0051	"Accept Nonimmigrant/Undocumented Immigrant Emergency Excess Income"
•	C22	Y0052	"Accept Nonimmigrant/Undocumented Immigrant Emergency Coverage Only"
•	S78	Y0057	"Accept Nonimmigrant/Undocumented Immigrant Emergency Excess Resources"
•	S79	Y0058	"Accept Nonimmigrant/Undocumented Immigrant Emergency Excess Income and Resources"

- E0007 "Explanation of the Excess Income Program for Nonimmigrant/Undocumented Immigrant Emergency Only"
- E0008 "Explanation of the Excess Resource Program for Nonimmigrant/Undocumented Immigrant Emergency Only"

In addition, revisions were made to existing CNS notices (denials and discontinues) to reflect the Aliessa court decision. The language has been changed to include additional categories of immigrants not included in current notices.

New York City should use the approved language from the body of the Upstate CNS notices for their manual notices.

We anticipate the CNS notices migrating in November 2004, will cover most contingencies. However, in the unlikely event the LDSS must use a manual notice, local districts are reminded to use the following language to deny/discontinue undocumented immigrants and temporary nonimmigrants (i.e. formerly called "nonqualified/non-PRUCOL aliens"):

> "This is because you are not a citizen, qualified alien or permanently residing in the United States under color of law (PRUCOL).
>
> To be eligible for New York State Medicaid Programs, individuals must be a U.S. citizen, national, Native American or have satisfactory immigration status.

An individual with satisfactory immigration status will fall under one of the following categories:

Qualified "aliens" include the following immigrants:

- persons lawfully admitted for permanent residence;
- persons admitted as refugees;
- persons granted asylum;
- persons granted status as Cuban and Haitian entrants;
- persons admitted as Amerasian immigrants;
- persons whose deportation has been withheld;
- persons paroled into the United States for at least one year;
- persons granted conditional entry;
- persons determined to be battered or subject to extreme cruelty in the United States by a family member;
- Victims of trafficking; or
- Veterans or persons on active duty in the Armed Forces and their immediate family members.

PRUCOL "aliens" include the following immigrants:

- persons paroled into the United States for less than one year;
- persons residing in the United States pursuant to an Order of Supervision;
- persons residing in the United States pursuant to an indefinite stay of deportation;
- persons residing in the United States pursuant to an indefinite voluntary departure;
- persons on whose behalf an immediate relative petition has been approved and their families covered by the petition;
- persons who have filed applications for adjustment of status that INS has accepted as "properly filed" or has granted;
- persons granted stays of deportation;
- persons granted voluntary departure;
- persons granted deferred action status;
- persons who entered and continuously resided in the United States before January 1, 1972;
- persons granted suspension of deportation; or
- other persons living in the United States with the knowledge and permission or acquiescence of the USCIS and whose departure the USCIS does not contemplate enforcing. Examples include but are not limited to the following:
    - permanent non-immigrants, pursuant to Public Law 99-239 (includes Citizens of the Federated States of Micronesia and Marshall Islands);
    - applicants for adjustment of status, asylum, suspension of deportation or cancellation of removal, or deferred action or persons granted extended voluntary departure, or Deferred Enforced Departure (DED) for a specified time due to conditions in their home country;
    - persons granted Family Unity; or
    - persons granted Temporary Protected Status.

Some immigrants maybe lawfully admitted to the United States, but only for a temporary or specified period of time as legal nonimmigrants (i.e. tourists, short term visa holders and foreign students). These immigrants are not eligible for Medical Assistance under Medicaid because of the temporary nature of their admission status. However, individuals who are not citizens, nationals, Native Americans or in satisfactory immigration status may receive Medical Assistance coverage ONLY for the treatment of emergency medical conditions, or for medical services provided to pregnant women, if they are otherwise eligible.

This decision is based on Regulations 18 NYCRR 360-3.2(j), 360-3.3, 360-4.8, Section 122(1)(e) of the Social Services Law and General Information System (GIS) 01-MA-026 and 01-MA-030.

NOTE: Undocumented immigrants and temporary nonimmigrants are eligible only for coverage for the treatment of an emergency medical condition, if they meet all other eligibility requirements.

VI. EFFECTIVE DATE

The provisions of this OMM/ADM are effective immediately.

Kathryn Kuhmerker, Deputy Commissioner
Office of Medicaid Management

TAB G

He-W 606.02 Citizenship/Alien Status.

(a) Citizenship or alien status shall be verified at each assistance group member's initial determination of eligibility.

(b) Acceptable verification of U.S. citizenship status shall include the following:

(1) A birth record such as, but not limited to, the following:

a. Birth certificate; or

b. Other birth record which indicates that the individual was born in the U.S. or in a U.S. territory;

(2) U.S. passport;

(3) Certificate of citizenship or naturalization; or

(4) For newborns in the NHEP/FAP medical assistance program, up to age one year only, any other documentation of U.S. citizenship, provided such documentation substantiates that the newborn was born in the U.S. or a U.S. territory, such as:

a. A signed, written and dated statement from an individual such as a friend, relative or physician who has knowledge of the newborn's date and place of birth; or

b. A bill from a hospital or birthing center for the child's delivery.

(c) Acceptable verification of immigrant status shall be documentation issued by the U.S. citizenship and immigration services (USCIS) stating that:

(1) The individual's deportation has been withheld under 8 USC 1253;

(2) The noncitizen has been admitted as a refugee under 8 USC 1157;

(3) The noncitizen has been admitted as an asylee under 8 USC 1158; or

(4) The individual has been granted status as a lawful temporary or permanent resident under 8 USC 1255.

(d) Refusal or failure to verify citizenship, alien status or sponsor status shall result in the denial or termination of financial and medical assistance for the entire assistance group.

(e) Verification of the financial status of an alien's sponsor shall be as follows:

(1) Acceptable verification that the sponsoring organization or agency is no longer able to meet the alien's needs shall be a completed, signed and dated Form 769, Alien Sponsor's Affidavit of Non-Support; or

(2) Acceptable verification that a sponsoring organization or agency no longer exists shall be the alien's signed and dated written statement to that effect.

Source. (See Revision Note at Chapter Heading He-W 600) #5171, eff 6-26-91; ss by #6531, INTERIM, eff 6-

27-97, EXPIRES: 10-25-97; ss by #6614, eff 10-24-97; ss by #8452, eff 10-22-05

He-W 606.03 - He-W 606.09 - RESERVED

Source. (See Revision Note at Chapter Heading He-W 600) #5171, eff 6-26-91

TAB H

General Non-Financial and Financial Eligibility Requirements

for the Categorically Needy and the Medically Needy

37.82.401 CITIZENSHIP AND ALIENAGE (1) As a condition of eligibility for medicaid, an otherwise eligible individual must be either:

(a) a citizen of the United States; or

(b) a qualified alien as defined in ARM 37.78.220 lawfully admitted for permanent residence or who entered the U.S. after August 22, 1996, otherwise permanently residing in the United States, including any alien who is lawfully present in the United States under authority of sections 203(a)(7) or 212(d)(5) of the Immigration and Nationality Act.

(c) a non-citizen legal alien living in the U.S. prior to August 23, 1996. (History: Sec. 53-6-113, MCA; IMP , Sec. 53-6-131, MCA; NEW, 1982 MAR p. 729, Eff. 4/16/82; AMD , 1998 MAR p. 3281, Eff. 12/18/98; TRANS , from SRS, 2000 MAR p. 476.)

TAB I

Center on Budget and Policy Priorities

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June 16, 2006

HHS GUIDANCE WILL EXACERBATE PROBLEMS CAUSED BY NEW MEDICAID DOCUMENTATION REQUIREMENT

Judith Solomon and Andy Schneider

The Deficit Reduction Act (DRA) of 2005 imposes a new documentation requirement on the more than 50 million U.S. citizens now covered by Medicaid, as well as on citizens who will need the program's health and long-term care services in the future. Starting July 1, all U.S. citizens applying for Medicaid or renewing their Medicaid eligibility will have to prove their citizenship by presenting a U.S. passport or the combination of a U.S. birth certificate and an identification document. Individuals who cannot do so will be denied health services financed with federal Medicaid funds.[1] (The requirement does not apply to legal immigrants, who for many years have been required to demonstrate satisfactory immigration status and financial need in order to qualify for Medicaid.)

On June 9 — just three weeks before this new requirement will take effect — the Centers for Medicare & Medicaid Services (CMS) at the U.S. Department of Health and Human Services issued guidance to state Medicaid agencies explaining the requirement and what individuals and states must do to comply with it.[2] *The guidance makes the documentation requirements far more burdensome on U.S. citizens and state Medicaid agencies than is required by the DRA or needed to ensure that U.S. citizens are in fact U.S. citizens.* Under the terms of the guidance:

- U.S. citizens applying for or renewing their Medicaid coverage must produce passports or birth certificates to prove their citizenship unless they can show these documents do not exist or cannot be obtained within a reasonable period of time.

- All documents provided to meet the requirement must either be originals or copies certified by the issuing agency.

- U.S. citizens who apply for Medicaid and meet all eligibility criteria cannot receive coverage for needed health or long-term care services until they have produced the required documents proving that they are citizens. The guidance prohibits states from making coverage available

[1] The new requirement is at section 6036 of the Deficit Reduction Act. For more information about the provision, see "The New Medicaid Citizenship Documentation Requirement: A Brief Overview," Center on Budget and Policy Priorities, April 20, 2006.

[2] The guidance was issued as a State Medicaid Director Letter, SMDL# 06-012. CMS plans to issue "interim final" regulations prior to July 1. Public comments will be accepted on these regulations, but the regulations will be effective while comments are being received and considered.

Survey Finds Documentation Requirement Could Jeopardize Medicaid Coverage for 3 to 5 Million U.S. Citizens

- A nationally representative survey of 2,026 adults, commissioned by the Center on Budget and Policy Priorities and conducted by the Opinion Research Corporation in January 2006, found that roughly 3.2 to 4.6 million U.S.-born citizens now on Medicaid are at risk of losing coverage under the new requirement because they do not have a U.S. passport or birth certificate readily available. This group consists of:

- *About 1.7 million U.S.-born adults on Medicaid.* About one in every twelve (8 percent) U.S.-born adults age 18 or older who have incomes below $25,000 report they do not have a U.S. passport or U.S. birth certificate in their possession. This indicates that about 1.7 million U.S.-born adults covered by Medicaid could either lose their health insurance because of the new requirement or experience delays in obtaining coverage as they attempt to secure these documents.

- *Between 1.4 and 2.9 million U.S.-born children on Medicaid.* More than one-tenth of U.S.-born adults with children who have incomes below $25,000 reported they did not have a birth certificate or passport for at least one of their children. This indicates that between 1.4 and 2.9 million children enrolled in Medicaid apparently do not have the paperwork required.

Groups that the survey found to be at higher risk of lacking the required documents included African Americans, senior citizens, and residents of rural areas.

Source: Leighton Ku, Donna Cohen Ross and Matt Broaddus, "Survey Indicates the Deficit Reduction Act Jeopardizes Medicaid Coverage for 3 to 5 Million U.S. Citizens, Center on Budget and Policy Priorities, revised February 17, 2006.

while the applicant attempts to obtain a passport or birth certificate. Delaying coverage for applicants in this way is a significant departure from the draft guidance that HHS circulated in May. The draft guidance would have allowed U.S. citizens who meet all other eligibility requirements to receive Medicaid coverage while they obtain the documents that prove their citizenship. By contrast, under the final guidance, low-income children, parents, seniors and people with disabilities who have applied for passports, copies of their birth certificates, or other documents will be denied coverage for health care services while they wait for government agencies to provide these documents.

- The documentation requirement will even apply to seniors and people with physical or mental disabilities who are Medicare beneficiaries, as well as to seniors and people with disabilities who receive SSI benefits, all of whom have already had their citizenship verified by the Social Security Administration. Many of these people may now be in a physical or mental state that makes it difficult, if not impossible, for them to produce these documents (and in some cases, even to comprehend what they are being asked to do).

- State Medicaid agencies will have to obtain documents showing that U.S. citizen children in foster care are citizens, even though state child welfare agencies have already verified that fact in determining these children's eligibility for federal foster care payments.

These provisions are likely to result in delays and outright denials of coverage for many U.S. citizens applying for Medicaid, as well as the loss of coverage for many U.S. citizens now enrolled in Medicaid. As a result, the number of uninsured American citizens is likely to rise significantly, and the amount of uncompensated provided by hospitals and other health care providers is likely to increase markedly as well.

Adding to this problem, although the DRA requires HHS to undertake an outreach program to educate beneficiaries about the new citizenship documentation requirement and what they need to do to comply, CMS has yet even to start this outreach program. HHS has not launched this effort even though the law clearly states that the outreach program shall commence "as soon as practicable after enactment." The DRA was enacted on February 8.[3]

Passport or Birth Certificate Will Be Required in Most Cases

Under the DRA, U.S. citizens who produce a passport have satisfied the requirement to document their citizenship. Recognizing that many low-income Medicaid beneficiaries do not have passports (which are costly to obtain), the DRA also allows U.S. citizens to document their citizenship through a U.S. birth certificate (or other proof that they were born in the United States) plus a driver's license or other document proving their personal identity.[4]

In addition, the DRA gives the Secretary of HHS discretion to specify additional documents that provide proof of U.S. citizenship or a reliable means of documenting personal identity. Instead of using this discretion to make the documentation requirement less burdensome for U.S. citizens and state Medicaid agencies, however, CMS has made the requirement far more burdensome than necessary. The June 9 guidance establishes a hierarchy of acceptable documents and directs states to ask for documents at the highest level of reliability before accepting a document of lesser reliability. Only if a document does not exist or cannot be obtained within a reasonable period may a state accept a document of lesser reliability.[5] There is no reference to such a hierarchy process in the DRA.

"Primary" documents, considered by the June 9 guidance to be the most reliable, are passports and certificates of naturalization. If these documents are not available, the state can accept "secondary" documents. This suggests that states will have to require individuals to produce passports whenever possible.

U.S. citizens who cannot provide "primary" documents to meet the documentation requirement must provide proof both of citizenship and of their personal identity. The guidance considers birth

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[3] Section 6036(c) of the Deficit Reduction Act, P.L:. 109-171. The June 9 guidance states that CMS "will implement an outreach plan" to explain the new documentation requirement but does not specify when or how.

[4] Passports cost $97 for individuals over age 16 and $82 for those under 16. Getting passports on an expedited basis costs an additional $60.

[5] The guidance measures a "reasonable opportunity" period to obtain documents by the time limits to determine eligibility for benefits. That time period is 45 days for everyone except people with disabilities, who have 90 days to establish that they meet Medicaid eligibility requirements. 42 CFR §435.911.

certificates, along with several other documents such as final adoption decrees and official records of military service, to be "secondary evidence" of citizenship.

Most of the documents that the guidance lists as acceptable proof of identity, such as a driver's license or a school identification card, include a picture of the individual. Many people with disabilities do not have such documents. Yet the guidance makes no provision to help people with disabilities prove their identity. The guidance fails to include a provision specifically referenced in the DRA that would allow people with disabilities to use affidavits from nonprofit organizations to prove their identity.[6]

If the state determines that "secondary" evidence does not exist or cannot be obtained in a reasonable period, the guidance includes third and fourth levels of reliable evidence. One example of a "third level" document is a hospital record, created at least five years before the individual applied for Medicaid, that indicates a U.S. place of birth.

The guidance states that "fourth level" evidence of citizenship may "ONLY be used in the rarest of circumstances," when all other levels of evidence do not exist or cannot be obtained within a reasonable period. One example of a "fourth level" document is a written affidavit. Two affidavits must be submitted, one of which must be from a person not related to the applicant or beneficiary. Persons making the affidavits must themselves be able to prove their citizenship and identity and must have personal knowledge of the "event(s)" establishing the applicant or beneficiary's citizenship, presumably his or her birth. Such affidavits are not likely to be helpful for most applicants and beneficiaries who have been unable to provide other proof, because these individuals will probably not have ready access to two people who have personal knowledge of their birth.

The hierarchy specified by the June 9 guidance is likely to put many vulnerable U.S. citizens at risk of having their Medicaid coverage terminated, denied, or delayed. For example:

- An elderly U.S. citizen who has Alzheimer's and resides in a nursing home might lose Medicaid coverage that pays for her care because her birth certificate cannot be located or she lacks a driver's license. Given her mental state, she likely would not be able to tell the nursing home staff where to apply to get her birth certificate and certainly would not be able to pass a driving test.

- A child who is a U.S. citizen and is placed in foster care because her mother is incarcerated or has disappeared or died may not receive Medicaid coverage for the health services she needs because a certified birth certificate cannot be located in her records.

- A low-income U.S. citizen who is diagnosed with breast cancer and otherwise qualifies for Medicaid may be delayed in receiving treatment for a number of weeks while she waits for a certified copy of her birth certificate.

- An elderly African American woman who was never issued a birth certificate (many elderly African Americans were born at home and never received a birth certificate because their parents did not have access to a hospital due to racial discrimination, especially if they were

[6] 8 CFR 274a.2(b)(1)(v)(B)(4).

born in the South in the early decades of the last century) and who has no living family members who could attest to her birth in the United States may lose Medicaid coverage.

All Documents Must Be Originals or Certified Copies

The June 9 guidance stipulates that all citizenship and identity documents presented by U.S. citizens seeking to secure or retain Medicaid coverage must be either originals or copies "certified by the issuing agency." The DRA has no such stipulation.

A certified copy of a birth certificate costs from $5 to $30, depending on the state. Normal processing times can range from several days to eight weeks, and expedited delivery can cost up to $60. These costs can be burdensome for Medicaid applicants and beneficiaries: most Medicaid beneficiaries have income below the poverty line.

Requiring certified copies also undermines efforts to make it easier for working families to apply and retain Medicaid coverage. As of July 2005, 45 states (including the District of Columbia) did not require a face-to-face interview when applying for Medicaid for a child, and 48 states (including DC) did not require a face-to-face interview when renewing coverage for a child. But after spending time and money to obtain a certified document to prove their citizenship, low-income individuals may be reluctant to take the chance of losing the document in the mail. Many likely will opt to visit the Medicaid eligibility office to apply for or renew their coverage, which may require them to take time off from work and lose some pay and may, in some cases, antagonize their employers.

Applicants' Coverage Will Be Delayed Until Required Documents Are Provided

The June 9 guidance prohibits states from providing Medicaid coverage to U.S. citizens who apply for Medicaid until they satisfactorily document their citizenship. This constitutes a step backward from a previous draft of the guidance, which would have allowed applicants to receive Medicaid while they obtained the needed documents.

Under the previous draft, which was circulated in May, U.S. citizens who signed a Medicaid application that included a declaration of citizenship and who met all other eligibility conditions could receive benefits while they obtained the documents needed to prove citizenship. (They would subsequently lose their eligibility if they failed to provide the documents.) States would receive federal matching funds for the costs of Medicaid services during this period of time. This approach parallels the treatment of legal immigrants under current law, who may receive Medicaid benefits during the time it takes them to obtain the documents they need to prove that they are in a legal immigration status.[7]

Under the June 9 guidance, in contrast, U.S. citizens applying for benefits will have to wait to obtain documents such as a passport or birth certificate before they can receive Medicaid coverage — even when they have made a sworn declaration that they are citizens, have met all eligibility requirements to receive Medicaid, and have applied for a passport or birth certificate and are waiting

[7] Section 1137(d)(4) of the Social Security Act.

to receive it. During this period, they may go without coverage for prescription drugs, doctor's visits, mental health treatment, and all other health care services unless their health care providers are willing to furnish such services free of charge.

Guidance Imposes Unnecessary Burdens on Medicare and SSI Recipients and Children in Foster Care

The millions of U.S. citizens affected by the DRA documentation requirement include more than six million seniors and people with disabilities now receiving both Medicaid and Medicare (more than one million of whom reside in nursing facilities), as well as seniors and people with disabilities who are receiving SSI benefits. Both of these groups already have had their citizenship verified by the Social Security Administration.[8] Yet the June 9 guidance does nothing to reduce the documentation burden on these U.S. citizens. It requires original documents or certified copies to be produced, and only allows the use of the information already in Social Security Administration databases after it has been determined that documents proving an individual's citizenship are not available.

In addition, Medicare or SSI recipients who are not currently receiving Medicaid but apply for Medicaid in the future could face substantial delays in receiving Medicaid coverage for nursing home care, home- and community-based services, or (in the case of SSI recipients) prescription drugs until they satisfactorily document their citizenship, as noted above.

The guidance also imposes an unnecessary documentation burden on U.S. citizen children who are in foster care. This is particularly unfortunate, because research has documented that children in foster care are much more likely to have chronic medical conditions and emotional problems than other children.[9] Currently, when a state child welfare agency determines that a child is eligible for federal foster care payments — a process that includes verifying that the child is a citizen or a legal non-citizen[10] — the state signs the child up for Medicaid benefits as well.[11] The new guidance ignores this longstanding linkage between Medicaid and foster care and forces state Medicaid agencies to duplicate the work of state child welfare agencies by documenting the citizenship of children whose citizenship (or legal status) has already been verified.

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[8] The language of the DRA suggests that Congress apparently intended to exempt most SSI recipients and dually eligible Medicare and Medicaid beneficiaries from the new documentation requirement. The law includes a provision that exempts "aliens" enrolled in these programs. This appears to be a drafting error in the legislation. As written, this provision has no meaning because it exempts aliens from a requirement that does not apply to them, and is applicable only to individuals who apply as citizens. This provision of the law makes sense only if the work "aliens" was meant to be "individuals," in which case most SSI recipients and dually eligible Medicare/Medicaid beneficiaries would be exempt. Reports have circulated for several months that at some point, a "technical corrections" bill may move in Congress to correct inadvertent drafting errors in the DRA, but no such legislation has yet emerged.

[9] U.S. General Accountability Office, "Foster Care: Health Needs of Many Young Children are Unknown and Unmet," GAO/HEHS-95-114 (1995).

[10] Administration for Children and Families, Child Welfare Policy Manual, Section 8.4B.

[11] Sections 402(a)(3) and 1902(a)(10)(A) of the Social Security Act.

This will not only create additional administrative costs and burdens for states, but also impose new paperwork requirements on foster families. It also could cause delays in Medicaid coverage for foster children if the documents needed to prove their citizenship are not immediately available.

Moreover, the guidance does not explain how documentation or declarations of citizenship can be obtained for children in foster care who are separated from their families. It also fails to explain whether state child welfare agencies are expected to share information with state Medicaid agencies despite confidentiality rules that protect state child welfare records. Making states obtain declarations and documentation of citizenship for these vulnerable children, while potentially jeopardizing these children's ability to receive necessary health care, makes little sense.

Conclusion

The documentation requirement imposed by the DRA is itself unnecessary. A comprehensive study conducted by HHS's Inspector General in 2005 found no substantial evidence that illegal immigrants are obtaining Medicaid by falsely claiming to be citizens. The requirement's main effect will be to make Medicaid less accessible to low-income U.S. citizens who qualify for the program.

HHS's June 9 guidance makes this bad situation worse by unnecessarily restricting the ways in which citizens can prove their citizenship, denying them needed health coverage while they obtain the required documents, and forcing state Medicaid agencies to document the citizenship of people who have already documented their citizenship through other programs. None of these harmful and wasteful provisions are mandated by the Deficit Reduction Act.

TAB J

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Centers for Medicaid and State Operations

SMDL: 06-012

JUN - 9 2006

Dear State Medicaid Director:

This is one of a series of letters that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA) enacted on February 8, 2006. (Pub. L. No. 109-171). Section 6036 of the DRA, Improved Enforcement of Documentation Requirements, creates a new subsection 1903(x) of the Social Security Act (the Act) that requires individuals claiming U.S. citizenship to provide satisfactory documentary evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first Medicaid redetermination on or after July 1, 2006.

Prior to enactment of this provision, in order for an individual to qualify for Medicaid, the applicant had to declare under penalty of perjury (under section 1137(d)(1)(A)) that he/she is a national or citizen of the United States, and, if not a citizen or national of the United States, that the individual is in a satisfactory immigration status. 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 such a claim. However, the individuals who declared they were aliens in a satisfactory immigration status were required in every State to provide documentary evidence of that claim. The new provision under Section 6036 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 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 in order to obtain Federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring.

Section 6036 specifies certain forms of acceptable evidence of citizenship or nationality and identity that are effective July 1, 2006. We have marked documents listed in section 6036 with asterisks "***" in the charts that follow. The statute also provides the Secretary with authority to specify, by regulation, other documents that provide proof and a reliable means of documentation of United States citizenship or nationality and personal identity. CMS plans to publish regulations that would exercise this authority. CMS has included documents it is, at present, considering utilizing in its upcoming rulemaking in the charts that follow.

A. Establishing United States (U.S.) Citizenship and Identity

Note: State Medicaid Agency determinations of citizenship are not binding on other federal agencies for any other purposes.

To establish U.S. citizenship the document must show:
- A U.S. place of birth, or
- That the person is a U.S. citizen.

Note: Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens.

To establish identity a document must show:
- Evidence that provides identifying information that relates to the person named on the document.

B. Documents Establishing U.S. Citizenship and Identity

The following Charts list acceptable evidence of U.S. citizenship and/or identity. Charts 1-4 address citizenship and Charts 1 and 5 address identity. If an individual presents documents from Chart 1 no other information would be required. If an individual presents documents from Charts 2-4, then an identity document from Chart 5 must also be presented. Charts 1-4 establish a hierarchy of reliability of citizenship documents and the following instructions specify when a document of lesser reliability may be accepted by the State. The State would make the decision whether documents of a given level of reliability are available. See discussion of additional documents for use when a child is 16 years of age or younger.

1. Primary Documents to Establish Both U.S. Citizenship and Identity (See Chart 1)

Primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. In general, obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in this Chart as primary evidence of both U.S. citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Note: Persons born in American Samoa (including Swain's Island) are generally U.S. non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals with respect to these persons. There is no difference in terms of Medicaid eligibility.

Note: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by U.S. Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

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.

Chart 1

Primary Documents	Explanation
***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.
***Certificate of Naturalization (N-550 or N-570)	Department of Homeland Security issues for naturalization.
***Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

2. Secondary Documents to Establish U.S. Citizenship (See Chart 2)

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 as described in item 5, Evidence of Identity.

Available evidence is evidence that exists and can be obtained within your State's reasonable opportunity period. The reasonable opportunity period is discussed under the heading "Reasonable Opportunity".

Accept any of the documents listed in this Chart as secondary evidence of U.S. citizenship if the document meets the listed criteria and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

Applicants or recipients born outside the U.S. must submit a document listed under primary evidence of U.S. citizenship.

Chart 2

Secondary Documents	Explanation
A U.S. public birth record showing birth in: • one of the 50 U.S. States; • District of Columbia; • American Samoa • Swain's Island *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917); • *Northern Mariana Islands (after November 4, 1986 (NMI local time)); or • Guam (on or after April 10, 1899)	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. *See additional requirements for Collective Naturalization.
***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, D.C. 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.
***Consular Report of Birth Abroad of a Citizen of the United States of America (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.
***Certification of Birth Abroad (FS-545)	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.
***United States Citizen	INS issued the I-179 from 1960 until 1973. It revised the form and

Identification Card (I-197) or the prior version I-179 (Section 6036 referred to these documents in error as an I-97.)	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.
American Indian Card (I-872)	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.
Northern Mariana Card (I-873)	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.
Final adoption decree	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.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government before June 1, 1976
Official Military record of service	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)

3. Third Level Documents to Establish U.S. Citizenship (See Chart 3)

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 item 5, Evidence of Identity.

Accept any of the documents listed in this Chart 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 (e.g., 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.

Chart 3

Third Level Documents	Explanation
Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial application date and indicates a U.S. place of birth	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.
Life or health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date	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.

4. Fourth Level Documents to Establish U.S. Citizenship (See Chart 4)

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 item 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Accept any of the documents listed in this Chart 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 (e.g., lost U.S. citizenship). In addition, a second document establishing identity must be presented.

Fourth level evidence, as described below, 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 Chart may be used only when the State is unable to secure evidence of citizenship listed in any other Chart.

Chart 4

Fourth Level Documents	Explanation
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for	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

persons born 1900 through 1950).	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.
Other document as listed in the explanation that 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: • Seneca Indian tribal census record • Bureau of Indian Affairs tribal census records of the Navaho Indians • U.S. State Vital Statistics official notification of birth registration • An amended U.S. public birth record that is amended more than 5 years after the person's birth • Statement signed by the physician or midwife who was in attendance at the time of birth
Institutional admission papers from a nursing home, skilled nursing care facility or other institution and was created at least 5 years before the initial application date and indicates a U.S. place of birth	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.
Medical (clinic, doctor, or hospital) record and was created at least 5 years before the initial application date and indicates a U.S. place of birth	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.
Written Affidavit	Affidavits should ONLY be used in rare circumstances. An affidavit by at least two individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. The person(s) making the affidavit must be able to provide proof of his/her own citizenship and identity for the affidavit to be accepted. If the affiant has information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained,

	the affidavit should contain this information as well. It must also be signed under penalty of perjury by the person making the affidavit. A second affidavit from the applicant/recipient or other knowledgeable individual explaining why documentary evidence does not exist or cannot be readily obtained must also be requested.

5. Evidence of Identity (See Chart 5)

Section 1903(x) provides that identity must be established. When primary evidence of citizenship described in number 1 above is not available, a document from the lists in number 2 through 4 may be presented if accompanied by an identity document from this list.

Chart 5

Documents to Establish Identity	**Explanation**
Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.	Acceptable if the document carries a photograph of the applicant or recipient, or has other personal identifying information relating to the individual.
***Any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act	Use 8 CFR 274a.2(b)(1)(v)(B)(1). This section includes the following acceptable documents for Medicaid purposes: • 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. • School identification card with a photograph of the individual • U.S. military card or draft record • Identification card issued by the Federal, State, or local government with the same information included on driver's licenses • Military dependent's identification card • Native American Tribal document • U.S. Coast Guard Merchant Mariner card Note: For children under 16, school records may include nursery or daycare records. If none of the above documents in the preceding charts 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.

	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).

Collective Naturalization

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;
- 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
- 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);
- 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
- 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).

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.

Treatment of Title IV-E Children and Individuals Receiving Services through Medicaid Section 1115 Demonstrations

Title IV-E children receiving Medicaid 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 subject to this provision. This includes expansion eligible individuals under statewide section 1115 demonstrations and family planning demonstrations.

Driver's License Documentation to Establish Both Citizenship and Identification

Section 6036(a)(3)(B)(iv) of the DRA permits the use of a valid State-issued driver's license or other identity document described in Section 274A(b)(1)(D) of the Immigration and Nationality Act, but only if the State issuing the license or such document requires proof of United States citizenship before issuance of such license or document 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. CMS is not currently aware that any State has these processes in place at this time. Therefore, until such time that a State has this requirement in place this documentation may not be accepted.

Effective Date

For new Medicaid applicants or for currently enrolled individuals, the State must obtain evidence of citizenship at the time of application or at the time of the first redetermination occurring on or after July 1, 2006. Recipients will need to provide such documentation only once unless doubt is cast on the situation because once citizenship is established it is a circumstance not likely to change.

Reasonable Opportunity

Beginning July 1, 2006 self attestation of citizenship by applicants or recipients will no longer be acceptable. Therefore, 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. For individuals who are already Medicaid recipients, such individuals remain eligible until determined ineligible as required by Federal regulations at 42 CFR 435.930. 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. 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 42 CFR 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 such cases, the State should assist the individual in securing evidence of citizenship. In these situations, States may use matches with other agencies to assist applicants or recipients to meet the requirements of the law. For example, States already receive the State Data Exchange (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. The BENDEX record is an extract of the Master Beneficiary Record and it does not currently house any data on U.S. citizenship or alien status; therefore, this system may not be utilized. States may use matches with State vital statistics agencies to assist applicants or recipients to document citizenship.

Applicants or Recipients Needing Assistance

If the applicant or recipient 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 should assist the applicant or recipient to document U.S. citizenship and identity.

State Processes and Best Practices

- All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted.
- States must maintain copies in the case record or data base and make available for compliance audits.
- States may permit applicants and recipients to submit such documentary evidence without appearing in person at a Medicaid office.
- 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 and/or the agency that issued the document.
- 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.
- A number of States have long required their applicants to document citizenship. New York, New Hampshire, and Montana report that they have, as part of the Medicaid eligibility process, required documentation of citizenship for many years without undue hardship to either applicants or the State. New York and New Hampshire have published guidelines for documenting U.S. citizenship that generally mirror the list of acceptable documents contained in this letter. Any State that currently has a process in place to document citizenship should review this State Medicaid Director's letter and modify their process, as appropriate, to ensure conformity with Section 6036 of the Deficit Reduction Act of 2005.

Denial, Termination, Notice and Appeals

The enactment of section 6036 does not change any CMS policies regarding the taking and processing of applications for Medicaid except the new requirement for presentation of documentary evidence of citizenship. Thus, the requirement that determination of Medicaid eligibility be performed in a manner consistent with proper and efficient administration continues to apply. Likewise, the regulations at 42 CFR 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 recipient or that individual's representative, after being notified, to take a required action. Notice and appeal rights and adequate and timely notice must be given to beneficiaries if the State denies or terminates an individual for failure to cooperate with the requirement to provide documentary evidence of citizenship. In the case of recipients, the notice must be in advance.

Federal Financial Participation (FFP) for Administrative Expenditures
CMS will provide FFP for State expenditures to carry out the provisions of section 1903(x) at the match rate for program administration.

Compliance
FFP will not be available if a State does not require applicants and recipients to provide satisfactory documentary evidence of citizenship, or does not secure such documentary evidence which includes the responsibility to accept only authentic documents on or after July 1, 2006. The Centers for Medicare & Medicaid Services (CMS) will review implementation of section 6036 to determine whether claims for FFP for services provided to citizens should be deferred or disallowed. Additionally, CMS 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.

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, CMS, in cooperation with other agencies of the federal government, is establishing 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 fifth level documents to verify identity , and CMS will make available to States necessary information in this regard in a future State Medicaid Director's Letter . States are hereby directed to 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.

Outreach Plan
CMS will implement an outreach plan to explain the requirements of section 1903(x). In addition, we will place on our website tools States may use in conducting similar outreach. Meanwhile, we encourage States to alert your Medicaid beneficiaries and potential applicants as soon as possible about the requirement to provide acceptable documentary evidence of citizenship upon Medicaid application or upon initial redetermination and how the requirements

may be met. We encourage States to work with organizations and applicants in meeting this requirement. Also, we encourage States to begin reviewing files and procedures to determine what information is currently on hand to minimize the workload associated with this requirement beginning July 1, 2006. We are confident that your implementing procedures will assure compliance with this requirement.

Questions

Questions regarding this provision may be directed to Jean Sheil, Director, Family and Children's Health Programs Group at 7500 Security Blvd., Mail Stop S2-01-16, Baltimore, Maryland 21244-1850.

Sincerely,

Dennis G. Smith

Dennis G. Smith
Director

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Administration

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Garden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrara
Director, Health and Human Services Task Force
American Legislative Exchange Council

Lynne Flynn
Director for Health Policy
Council of State Governments

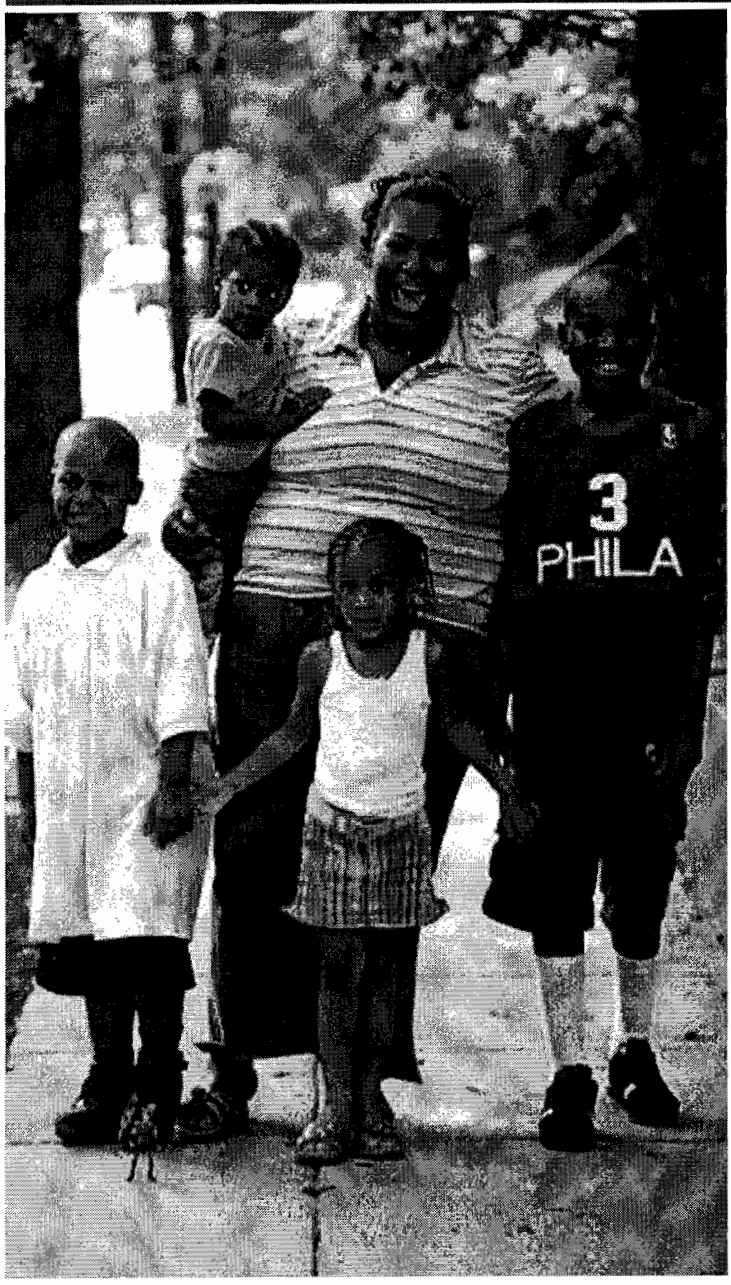
TAB K

Working Together for Health

MEDICAID ANNUAL REPORT
FY 2005

Government of the
District of Columbia
Anthony A. Williams, Mayor

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION



Working Together for Health

MEDICAID ANNUAL REPORT FY 2005

D.C. DEPARTMENT OF HEALTH
MEDICAL ASSISTANCE ADMINISTRATION

Quality Health Care for Vulnerable Populations

A Message from the Director, Department of Health

I WANT TO EXPRESS MY CONGRATULATIONS TO THE MANAGEMENT AND STAFF of the Medical Assistance Administration for the progress they have made over the last year in ensuring the provision of a wide range of quality health services to the residents of the District of Columbia. The Department of Health is proud to be the agency to carry out the Mayor's vision of providing quality health services for the most vulnerable populations of the District of Columbia.

"We are on our way to making D.C. one of the healthiest cities in the country."

Medicaid services are essential for the over 140,000 residents (one in four District residents) who are served every month through the program. The breadth of services encompasses the entire spectrum of our population, from the newborns to our senior citizens. Through sound management and oversight, we continue to ensure that comprehensive health services are provided to our members.

This annual report on Medicaid services in the District is a testimony to all of you who work with the Department of Health and Medicaid to ensure we meet the health needs of our citizens. We are on our way to making D.C. one of the healthiest cities in the country.

Gregg A. Pane, MD
Director, Department of Health

Our Responsibility to Over 140,000 Residents

A Message from the Medicaid Director

OVER THE PAST TWO YEARS, THE DISTRICT OF COLUMBIA'S MEDICAID PROGRAM HAS FOCUSED on becoming a world-class health insurance program. New programs to provide care for those most in need have been developed, eligibility for Medicaid has been expanded, collaborative community, advocacy and provider relationships have been established, and fiscal integrity has been restored. I am proud of all of the Medicaid staff and their desire to ensure that our Medicaid recipients get the best possible health care.

The Medicaid budget will approach $1.4 billion in FY 2006. We serve over 140,000 of the District's residents—one of every four residents—a number that continues to grow every month. We do not take this responsibility lightly. We are committed to working closely with the Mayor's office, with the Council, and with sister agencies to ensure that quality care is provided in a coordinated and effective manner.

"We are committed...to ensure that quality care is provided in a coordinated and effective manner."

Our program provides a wide variety of benefits and services for our beneficiaries. Children, parents, childless adults and elders are all eligible to receive services from the Medicaid program. Over 90,000 of our beneficiaries are served through our managed care organizations (MCOs). To ensure quality of care in these programs, we have worked closely with the National Committee for Quality Assurance (NCQA). To maintain NCQA accreditation, plans must meet high standards of quality that are measured for ongoing improvement. We are requiring our MCOs to become members of NCQA, a nationally recognized organization, to ensure better quality reporting and oversight. Additionally, we have instituted a process for them to report annually on 41 nationally recognized quality measures. As you can see, we view quality of health care as an extremely important part of our service to our beneficiaries.

We continue to increase our efforts to work closely with other District government health providers, establishing waivers and state plan amendments to increase access to Medicaid services in other settings. This provides our beneficiaries with a continuity of care that heretofore has not been available. We are also increasing the scope and breadth of home and community-based services that are available, so that institutionalization is not the only option, and individuals who choose to live at home can now do so.

As you read through this report you will see evidence that many new initiatives are making Medicaid a better program for our District residents. I would be remiss if I did not thank the Mayor, the District Council, and the Department of Health and our community partners for their support of our efforts. It has been my pleasure to oversee this program for the past two years and I look forward to even greater achievements in the year ahead.

Robert T. Maruca, Medicaid Director and
Senior Deputy Director, Medical Assistance Administration
Department of Health

Highlights of Fiscal Year 2005 and a Look to 2006

THE MEDICAID PROGRAM IN FY 2005

■ **Enrollment.** In FY 2005, Medicaid enrollment averaged 141,941 people a month, or one quarter of the District's population. Enrollment increased over 2%. See page 5.

■ **Spending.** For the fiscal year ended September 30, 2005, Medicaid spending for health care was $1.26 billion, up 3.4% (preliminary data). Payment per enrollee per month was $741, up 1.3%. See page 7.

■ **Economic impact.** 92% of Medicaid payments are made to health care providers in the District. Medicaid also brings in about $900 million a year in federal funding to D.C. See page 17.

HIGHLIGHTS OF FY 2005

■ **New initiatives to help HIV-positive people stay healthy.** D.C. became the first Medicaid program to cover costly anti-retroviral drugs for HIV-positive people who are not yet sick enough to qualify for Medicaid under standard eligibility rules. The District also received a federal "Ticket to Work" grant so that HIV-positive people can keep Medicaid coverage while maintaining employment. See page 10.

■ **More emphasis on managed care quality.** Medicaid began requiring its three managed care organizations to report results on 41 nationally accepted measures of quality. In FY 2006, all MCOs will be required to seek accreditation by the National Committee for Quality Assurance. See page 8.

■ **Improved child immunization rates.** D.C. was one of two Medicaid programs nationwide that exceeded federally set goals for child immunization. See page 11.

■ **Increased recoveries.** Medicaid efforts to reduce fraud and abuse, to ensure that Medicaid is the insurer of last resort, and to claim rebates from drug manufacturers all resulted in increased dollar recoveries. See page 18.

■ **Eligibility simplified.** The Medicaid eligibility form was streamlined from 18 pages to 6 pages. See page 6.

MAJOR ISSUES AND INITIATIVES FOR FY 2006

■ **Expansion in coverage and federal funding.** D.C. has requested federal approval to expand Medicaid coverage to include 1,700 people now covered by the D.C. Health Care Alliance. The expansion would generate $19.0 million a year in new federal funding and free up District money that could be used to fund health care for other needy groups. See page 6.

■ **Implementation of the Medicare drug benefit.** On January 1, 2006, Medicare will implement its new drug benefit. For 16,000 D.C. Medicaid beneficiaries, Medicare will pay for drugs now paid for by Medicaid. We are working with Medicare, beneficiary advocates and provider associations to ensure a smooth transition. See page 11.

■ **Increased flexibility in home and community-based services (HCBS).** A new Medicaid initiative will give people receiving home and community-based services more autonomy in selecting the services they need and in choosing their caregivers. HCBS is a cost-effective program that helps people remain at home when their health conditions otherwise would require placement in an institution. See page 14.

■ **Value purchasing for prescription drugs.** In FY 2006, Medicaid intends to become a more effective purchaser of prescription drugs by implementing a preferred drug list and changing drug payments to reflect maximum allowable cost (MAC) benchmarks. See page 19.

Essential Health Care for D.C. Residents

An overview of the residents that Medicaid serves and the services provided.

AN ESSENTIAL PROGRAM FOR D.C. RESIDENTS

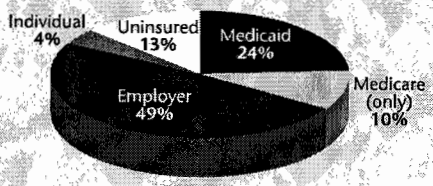
■ **2005 marks the 40th anniversary** of Medicaid and Medicare, two programs that have done enormous good for many millions of people who otherwise would have gone without health care coverage due to age, poverty or disability.

■ **Serving more D.C. residents every year.** In the 2005 fiscal year that ended September 30, D.C. Medicaid served an average of 141,941 residents a month. Since many beneficiaries moved on and off Medicaid during the year, the number of people served at various points during FY 2005 was even higher.

■ **How Medicaid fits in.** When it comes to health insurance, almost everyone in the U.S. comes under one of five categories.

- *Employment-based coverage* is the foundation of the system. When employers offer health plans, they pay an average of 75% of the cost, which now exceeds $10,000 a year for family coverage.[1] Unlike wage income, employees do not have to pay taxes on the health benefits they receive. But more and more employers do not offer health plans, especially to new hires, part-time workers or workers earning under $15 an hour.[2]

D.C. Health Insurance Coverage, 2003



Medicaid percentage includes 3% eligible for both Medicaid and Medicare.
Source: ACS Government Healthcare Solutions

- *Medicare* is available for people age 65 and over, regardless of income, and for people with certain disabilities that prevent them from working.
- *Individually purchased insurance* is bought by a few people, but is very expensive.
- *Medicaid* primarily serves low-income children and their parents, people with disabilities, and low-income Medicare beneficiaries.
- *The uninsured population* tends to include childless couples, single men and others who do not come under Medicaid eligibility categories, as well as people whose income exceeds Medicaid thresholds but who don't have access to employment-based coverage.

■ **The second-largest source of insurance.** Medicaid covers about one-quarter of the D.C. population in an average month. About half the D.C. population has employment-based coverage.[3] See the chart on this page.

■ **Critical for kids.** Medicaid covers 44% of D.C. kids age 18 and under while employment-based plans cover 43%, according to the Kaiser Commission on Medicaid and the Uninsured.[4]

Medicaid Population Demographics FY 2005

	Number	%
By Sex		
Male	57,185	40%
Female	84,756	60%
By Age		
17 and under	71,427	50%
18–21	9,019	6%
22–64	49,639	35%
65 and over	11,856	8%
By Race		
Black	124,181	87%
White	2,214	2%
Other	15,546	11%
By Ward		
1	15,218	11%
2	20,864	15%
3	1,649	1%
4	15,009	11%
5	18,969	13%
6	16,676	12%
7	24,199	17%
8	28,841	20%
Unknown	516	0%
TOTAL	**141,941**	**100%**

Note: Percentages may not sum to 100% due to rounding.

The Federal Poverty Line

Medicaid eligibility often depends on annual family income relative to the federal poverty line (FPL). This table shows the 2005 FPL.

Family Size	100% of FPL	150% of FPL	200% of FPL
1	$9,570	$14,355	$19,140
2	$12,830	$19,245	$25,660
3	$16,090	$24,135	$32,180
4	$19,350	$29,025	$38,700

CHANGES IN ELIGIBILITY

■ **Eligibility form simplified.** In FY 2005, the application for Medicaid benefits was reduced from 18 pages to 6 pages. The extra pages had been used to check for unusual sources of income and assets that rarely affected eligibility.

■ **Innovative waiver program will expand coverage.** In FY 2006, Medicaid intends to extend coverage to three groups of people:

- About 900 disabled people with incomes between 100% and 200% of the federal poverty line (FPL)
- About 300 19- and 20-year-olds
- About 500 unborn children of pregnant immigrant women

These groups are now covered by the D.C. Health Care Alliance, the program for the uninsured that is 100% funded by the District. Medicaid has requested federal approval to make these groups eligible for Medicaid, which is 70% funded by the federal government. The increase in Medicaid spending is expected to be about $27 million a year, mostly for the people with disabilities who have chronic health care needs. The inflow of federal money will free up District funds that can be used to fund health care for other needy groups. The new beneficiaries will be eligible for a broader range of services than they are now. By extending coverage to unborn children, Medicaid can fund prenatal care for low-income immigrant women. Prenatal care is among the most cost-effective ways to improve the health of the D.C. population, especially since many of these children become eligible for Medicaid at birth.

■ **Plan to expand benefits for dual eligibles.** Medicaid has requested federal approval to simplify eligibility standards for people dually eligible for Medicaid and Medicare. Currently, some Medicare beneficiaries can obtain full Medicaid benefits if their incomes are under 100% of the FPL. For another group of Medicare beneficiaries, Medicaid will pay their Medicare Part B premiums if their income is between 100% and 120% of the FPL, though they do not receive full Medicaid benefits. The plan is to increase both thresholds to 150% of the FPL, benefiting about 150 people at a total cost of about $200,000 a year.

Medicaid Spending by Fiscal Year Ending Sept. 30

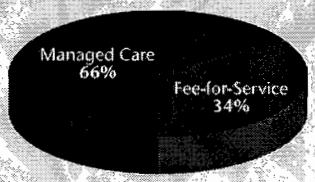
	FY 2004 Actual	FY 2005 Preliminary	FY 2006 Budgeted
Spending for Care	$1,221,035,000	$1,262,424,000	$1,337,198,000
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	$732	$741	$769

Note: The FY 2006 enrollee count assumes the same growth rate as was seen between FY 2004 and FY 2005. It is not an official MAA projection.

MEDICAID SPENDING AND SERVICES

■ **Spending trends.** Medicaid spending for care was $1.26 billion (preliminary data) in FY 2005, making Medicaid the largest item in the D.C. budget.[5] The increase over FY 2004 was 3.4%, reflecting a 2.1% increase in average monthly enrollment and a 1.3% increase in spending per enrollee per month. The 1.3% figure compares very well with the nationwide 9.2% increase in the average cost of an employment-based health plan.[6]

Medicaid Enrollment FY 2005
141,941 Monthly Average

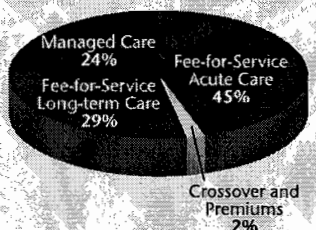


■ **A foundation of managed care.** Of total average enrollment of almost 142,000 people, about 94,000 are enrolled in managed care in a typical month. These beneficiaries are typically children and working age adults without disabilities. About one-quarter of the Medicaid budget is spent purchasing care for this group.

■ **Care for the elderly and people with disabilities.** The 48,000 beneficiaries not enrolled in managed care plans are typically elderly and/or disabled, with heavy health care needs. About 45% of the budget is spent on their physician visits, hospital care, prescription drugs and other acute care services. In addition, they are more likely to need long-term care, which accounts for about 29% of the budget.

■ **The most important payer for long-term care.** Medicaid is by far the largest payer for long-term care, which includes nursing facility care, home health care, personal care attendants and other home and community-based services. Private-sector plans rarely cover these services, while Medicare's long-term care benefits are much more limited than those of Medicaid.

Medicaid Spending FY 2005
$1.26 Billion (Preliminary)



■ **A big help to poor and ill Medicare beneficiaries.** About 16,000 D.C. residents are eligible for both Medicare and Medicaid. Medicaid is the major payer for their long-term care and prescription drug needs and also pays much of their Medicare cost-sharing obligations. About 2% of the budget is spent on Medicare premiums and cost-sharing amounts on "crossover" claims.

■ **Spending outlook.** Medicaid spending in FY 2006 is budgeted at $1.34 billion, a 5.9% increase from FY 2005.

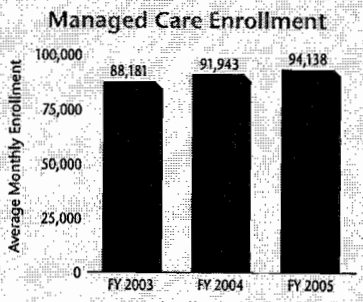
■ **Continued budget pressure.** Over the longer term, federal actuaries predict that Medicaid spending nationwide will outpace growth in national health spending. One factor—expected to account for about one-fifth of Medicaid spending growth—is the double-digit growth in home and community-based services, which allow elderly people and those with disabilities to remain at home instead of living in institutions.[7]

Managing Care for Health and Cost Control

Two-thirds of D.C. Medicaid beneficiaries receive health care from one of four managed care plans. Medicaid is taking strong steps to ensure the quality of care for plan beneficiaries.

■ **Medicaid managed care.** In 1994 the District began a major effort to promote managed care. In 1997, the District moved to mandatory enrollment for certain eligibility groups. Today, two-thirds of Medicaid enrollees belong to one of four managed care plans: AMERIGROUP, D.C. Chartered Health Plan, Health Right, and Health Services for Children with Special Needs (HSCSN).

■ **Managed care organizations.** AMERIGROUP, D.C. Chartered Health Plan and Health Right are managed care organizations (MCOs) that accept clinical and financial responsibility for almost all Medicaid services provided to their members, who are typically children and their non-disabled family members in the 21–64 age group.



■ **Special plan.** HSCSN manages care for children with disabilities. Medicaid beneficiaries enroll voluntarily in HSCSN; enrollment averaged 3,375 children a month in FY 2005. HSCSN is not at financial risk for the care its members receive. The plan is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

■ **Improving coordination of substance abuse care.** Outpatient care for substance abuse is one of the few services that the MCOs do not provide. Instead, this care is 100% funded by the D.C. government. In FY 2005, MAA requested federal approval to make outpatient care for substance abuse a Medicaid service, which would bring $3.0 million a year in new federal funding to the District. In addition to improved integration with other care received by MCO members, the change is expected to increase access to services, including residential substance abuse treatment for pregnant women.

■ **Expansion of MCO membership.** Several years ago, the District began enrolling childless adults 50 to 64 years old in Medicaid, so long as their incomes were below 50% of the federal poverty line. (This required a waiver of federal eligibility rules.) In FY 2005, this group of 1,362 people became MCO members. These beneficiaries will benefit from improved coordination of care.

■ **MCO quality to be evaluated using 41 measures.** In FY 2005, D.C. began requiring MCOs to collect and report standardized quality measures, such as child immunization rates, breast cancer screening rates and customer satisfaction scores. "This is a huge step towards expanding our quality improvement efforts by measuring performance on a richer set of standards," said Dr. Gregg Pane, Director of the Department of Health, in announcing the initiative. The measures are from the nationally recognized Health Plan Employer Data and Information Set (HEDIS), thereby enabling Medicaid and the MCOs to track quality of care over time and in comparison with national benchmarks.

■ **NCQA accreditation.** In FY 2006, Medicaid will require all MCOs to seek accreditation by the National Committee for Quality Assurance (NCQA). The NCQA, a national, not-for-profit organization, is often described as the watchdog of managed care. Teams of NCQA experts will visit each MCO to evaluate it on patient safety, service, confidentiality and other quality standards.*

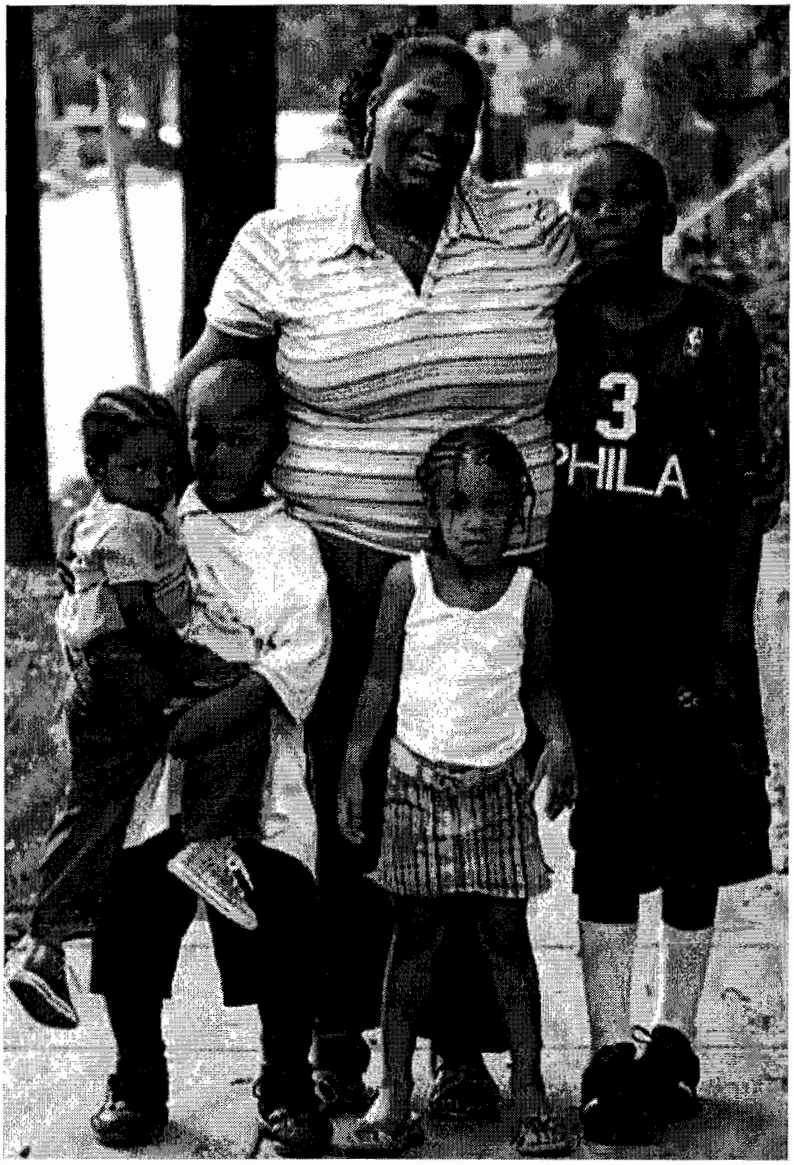
Carole Colbert and Family

"I thank God for Medicaid," says Carole Colbert, whose six children have all benefited from Medicaid coverage. Today, Ms. Colbert is raising her daughters Jewel, 2, and Aniya, 5, her son, Randy, 7, and her grandson Demetrius, 11.

Growing up was not easy for Ms. Colbert and her two siblings, who were raised by a single mother addicted to alcohol. As Ms. Colbert explains, "Mom didn't teach us about the 'birds and the bees,' so when I was coming up, I was always the one in trouble."

Pregnant at the tender age of 14, Ms. Colbert's children are as old as 27 and as young as 2. As Ms. Colbert explains, "Medicaid was always there to help."

Reflecting on an early experience with her oldest daughter, Ora, now 22 years old, Ms. Colbert recalls: "One day, Ora was just walking on the grass, and she twisted her leg on a piece of metal that was stuck in the grass." Ora had to be rushed to the hospital for knee surgery. "If it wasn't for Medicaid," she says, "I'd still be paying for it today."



Carole Colbert with daughters Jewel and Aniya, son Randy, and grandson Demetrius.

She also recalls a brief instance when she and her children experienced an interruption in coverage when she had to get recertified by Medicaid. During the recertification process, one of her kids needed medical attention. "After I spoke to the representative and explained my family situation," says Ms. Colbert, "Medicaid got me back on the program quickly. Medicaid is always on time."

"Just think, if my kids didn't get shots, they would not be in school."

Ms. Colbert also remembers what Medicaid was like before the District began working with managed care organizations to provide better access to quality health care. Ms. Colbert's family is enrolled in D.C. Chartered Health Plan and she sees the benefits for herself and her children today. "Before Chartered," she explains, "my children and I would miss doctors' appointments because I couldn't afford to get to the doctor, or I was too sick to get there. Once Chartered came along, they provided transportation for me and my kids so that I can take them to get their shots. Just think, if my kids didn't get shots, they would not be in school," Ms. Colbert says.

As a stay-at-home single parent with young children, Ms. Colbert needs to maintain her health. Medicaid has covered two surgical procedures for Ms. Colbert, including emergency surgery for a hernia. More recently, though, Ms. Colbert's primary care physician referred her to a specialist to manage other health problems. "When I think about the surgery I've needed and that I need to see a specialist, I would have been pulling my hair out to pay for this because no one is going to take me without Medicaid." Ms. Colbert concludes: "Just imagine if I didn't have Medicaid."

Here for Health

When Congress enacted Medicaid 40 years ago, the program looked more like a welfare program than a health program. Today, Medicaid provides insurance for over 41 million Americans, giving it a central place in the health care system. D.C. Medicaid sees its role as improving the health of District residents, often in collaboration with other agencies. In this section we describe a dozen such initiatives.

■ **Medicaid beneficiaries gain from Medicare disease management program.** In FY 2005, D.C. was selected to participate in Medicare Health Support, a demonstration program designed to improve health outcomes and reduce costs for people with multiple chronic diseases. About 1,600 D.C. residents dually eligible for Medicare and Medicaid can choose to participate in Medicare Health Support, which was previously called the Chronic Care Improvement Program. Participation is free. In D.C., the program is managed by American Healthways, a national disease management company selected by Medicare. Depending on their needs, participants may receive nurse counseling, home monitoring equipment, home visits and intensive case management. MAA's role in the demonstration is to help with outreach to beneficiaries and providers and to assist with data analysis.

■ **Standardized child health screening form will improve care.** In FY 2005, Medicaid piloted a standardized form for HealthCheck, the District's program to make sure every child gets early screening and treatment for health problems. (HealthCheck is the D.C. version of the national Medicaid program called EPSDT.) Medicaid collaborated with physicians and managed care plans to develop a new standardized medical record form for HealthCheck. The form, which is completed by the primary care provider, is designed to capture all aspects of a well-child visit, including the need for additional services such as dental or specialty care. The form will be fully implemented early in FY 2006. The District will become the only Medicaid program to have a centralized child health registry accessible to providers and managed care plans. The registry will enable MAA to make sure HealthCheck services take place. As well, authorized providers will be able to view a child's history of immunizations and preventive health care visits. This picture of a child's health status will enhance MAA's ability to perform quality of care analysis with providers. MAA also plans to incorporate lead-poisoning data in the registry in the near future.

Innovative Programs Help Keep HIV-Positive People Healthy

On January 14, 2005, D.C. became the nation's first Medicaid program to cover critical yet costly anti-retroviral drugs for HIV-positive patients with incomes below 100 percent of the federal poverty line (FPL). The result: 267 people get needed coverage and preventive services before they become disabled. Another program provides some HIV-positive people with high-quality home water filters, which screen out bacteria that can be fatal to immune-compromised patients. Both initiatives required waivers of federal Medicaid rules.

A third program, called "HIV Ticket to Work Independence," allows an average of 420 HIV-positive people a month to keep their Medicaid coverage even if employment raises their incomes up to 300% of the FPL. Ticket to Work, which is 95% funded by the federal government, started in April 2005.

These programs help HIV-positive people stay healthy and remain in the workforce as long as possible, thereby contributing to the District's economic development.

■ **Drug utilization review (DUR) board works for appropriate medication use.** The DUR board, comprising D.C. physicians and pharmacists, works to improve quality of care, which is especially an issue for beneficiaries with complex conditions who may receive several drugs prescribed by different physicians. Since Medicaid claim files provide an overview that no individual physician has, the board draws on these records to create and review 400 patient profiles a month. The focus is on potential issues related to drug-drug interactions, drug-disease interactions, and over- and under-utilization of medications. If a potential issue is deemed significant then the prescribing physician is alerted. The board also undertakes four educational campaigns a year targeted at physicians. In FY 2005, these campaigns focused on resistance to antibiotics, coronary artery disease, diabetes and congestive heart failure.

■ **Interagency collaboration to improve health of D.C. residents.** Better delivery of health care services sometimes requires better coordination of services. That was the conclusion of MAA and several other D.C. agencies that signed a July 2005 Memorandum of Understanding. Parties to the memorandum included the Department of Health, Department of Mental Health, Department of Child and Family Services, Department of Youth Rehabilitation Services, Maternal and Child Health Administration, Addiction Prevention and Recovery Administration, and the D.C. Public Schools. The intended results are increased efficiency, increased interagency data sharing, and better coordination of services.

Impact of the New Medicare Drug Benefit on Medicaid Beneficiaries

On January 1, 2006, about 77,000 Medicare beneficiaries in D.C. will become eligible for Medicare's new Part D prescription drug benefit. For residents who are dually eligible for Medicare and Medicaid, Medicare will start paying for the prescription drugs that Medicaid has paid for in the past. About 16,000 dually eligible beneficiaries will be affected.

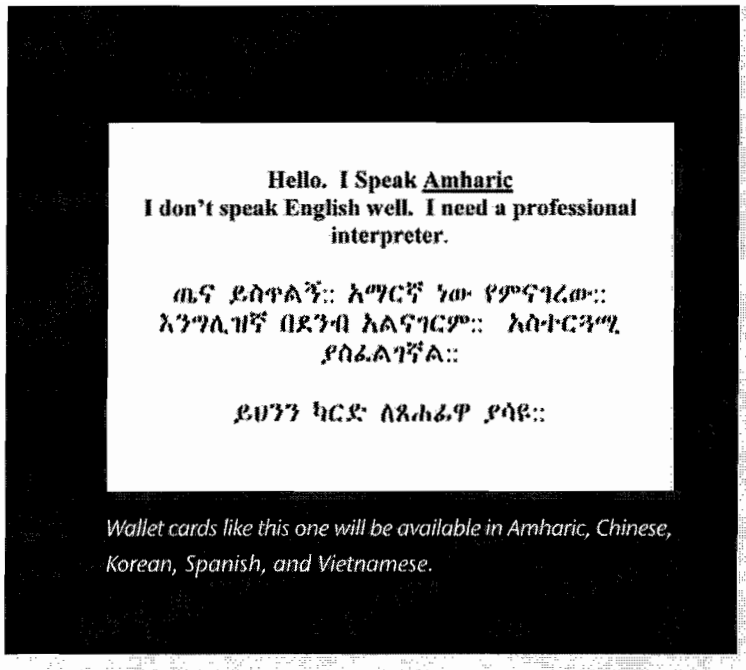
Our top priority is that Medicaid beneficiaries have no interruptions in the supply of essential medications. MAA is partnering with an extensive network of providers, pharmacists and advocacy groups to assist beneficiaries in making the transition. We are participating in educational forums for health care professionals, advocates and the public about this new and important benefit. We are also sharing information with beneficiaries through direct mail updates.

The new Medicare Part D benefit applies only to prescription drugs provided through pharmacies. Drugs provided to Medicaid beneficiaries in hospitals, physician offices, dialysis clinics and other settings are unaffected.

Beneficiaries and providers with questions about the new Medicare benefit can find information at www.cms.hhs.gov, www.medicare.gov and 1-800-MEDICARE (1-800-633-4227), TTY 1-877-486-2048.

■ **D.C. exceeds child immunization goal.** In June 2005, D.C. was recognized as one of two Medicaid programs nationwide that exceeded its child immunization goal under the federal Government Performance and Results Act of 1993. Working in collaboration with managed care plans, Medicaid providers, community-based organizations, and the Office of Immunization's Vaccines for Children Program, MAA increased the Medicaid immunization rate from 63% in October 2000 to 73% in October 2004, exceeding the original goal of 72% for children under two years old. The D.C. Medicaid immunization rate for school-age children is 95%.

■ **Focusing on childhood obesity.** Recognizing the increasing need to prevent obesity from an early age, participating managed care plans conducted a study to establish baseline data on obese and overweight children and youth. As a result of the study, MAA developed guidelines for the identification of care for obese/overweight children, adopted mandatory screening of two-year-olds to assess obesity/overweight symptoms based on height, weight and body mass index, developed an appropriate model for treatment, and trained managed care practitioners on the treatment model in June 2005. To ensure continued refinement of these efforts, MAA established the Obesity Prevention Advisory Committee, comprising D.C. agencies, the public schools, and community stakeholders.



Wallet cards like this one will be available in Amharic, Chinese, Korean, Spanish, and Vietnamese.

■ **Reaching out to non-English speaking communities.** Overcoming language barriers and improving communication is critical to increasing access to health care for the District's diverse population. Medicaid collaborated with community groups to develop a culturally sensitive brochure about beneficiaries' rights to interpreter services for health care. The brochure was field-tested to ensure wide acceptance among non-English speakers. In FY 2006, the brochure will be made available in Amharic, Chinese, Korean, Spanish, and Vietnamese, which, other than English, are the most prevalent languages spoken in the D.C. schools. In the past, no similar information had been provided to non-English speakers.

■ **Getting kids to the dentist.** Access to dental care for low-income children is a problem across the U.S., with fewer than 20% of Medicaid children having an annual dental visit.[9] Using a combination of focus groups, health fair participation, and increased outreach efforts in partnership with managed care plans, D.C. Medicaid boosted its rate from 20% in FY 2003 to 32% in FY 2004. (The FY 2005 rate is not yet available.) To maintain the momentum, MAA implemented a dental helpline in FY 2005 to help beneficiaries locate providers and intends to improve access by increasing fees paid to dentists in FY 2006.

■ **Preventing deaths from the flu.** The District of Columbia reported only one flu-related death in FY 2005, thanks in part to Medicaid's successful efforts to make flu shots available using the house call system despite limited supplies. Not one Medicaid beneficiary died of flu-related causes.

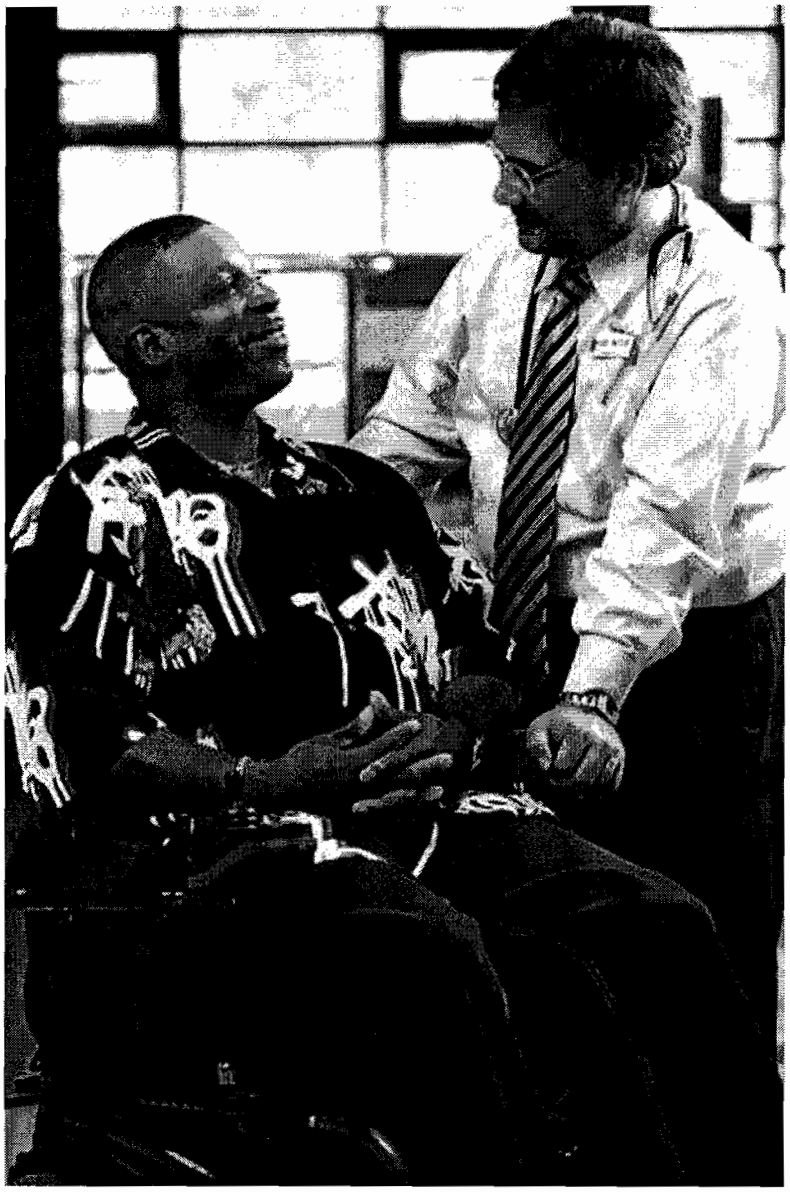
■ **Ensuring the confidentiality of beneficiaries' health information.** MAA was one of 10 District agencies involved in a citywide effort to upgrade policies, procedures and business processes to improve the security of beneficiaries' confidential health information. In compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), all MAA staff members now receive training in how to properly handle protected health information. In FY 2006 and FY 2007, MAA and other agencies will be working to implement additional HIPAA regulations designed to protect confidential health information.

Vincent Massey

Vincent Massey, then 35 years old, was washing his car when he was shot once in the leg and twice in the lungs. One bullet ricocheted inside his chest and lodged in his spine, where it remains today, seven years later. At that instant, his lower abdomen and legs became paralyzed. The drive-by gunman was never identified.

At D.C. General Hospital, a staff member had Mr. Massey fill out the forms that would qualify him for federal Supplemental Security Income and D.C. Medicaid benefits. He was transferred to the National Rehabilitation Hospital on Irving St. NW, which treated both the physical and mental after-effects. "When you get a jolt like that—losing your legs—you go through a depressive period," he says now. A hospital psychiatrist helped him get through it. Rehabilitation "built my morale up."

At first, he used an ordinary wheelchair. It made a big difference when a doctor said he needed a motorized chair. "It allowed me to just be normal. I don't have to stay in the house," he says. Rather than "watching TV, my mind going nowhere," Mr. Massey gets out every day, riding the Metro, going to appointments and visiting friends and family. He goes out so much that his wheelchair needs regular repairs. He also benefits from a stander, a device that helps him stand up, exercise his muscles, and avoid serious problems such as pressure sores.



Vincent Massey with his doctor, Sandeep Simlote, at the National Rehabilitation Hospital.

With therapy, he has regained some use of his lower abdomen and legs. Before, he couldn't move so much as a toe and he needed incontinence garments. Now, he can lift his feet off the footrests, reposition himself from the chair to a bed, and take himself to the bathroom. "I can move—things I couldn't do before," he says.

Last year the rehabilitation hospital asked Mr. Massey to participate in a study on investigational drugs to decrease involuntary muscle tightness. He undergoes four hours of tests each week. "I'm giving back for what's been given to me," he says.

"I'll put it this way... It (Medicaid) takes a broken person and makes him feel whole."

From here, Mr. Massey's goal is to move from his room in a group home into his own apartment, get a job, and continue improving his ability to move. "Hopefully, some day in the near future I'll be able to donate this chair to someone less fortunate," he says. "That's my goal." For now, he tells people how lucky he is. "I like to talk to people, to tell people how good God has been to me. Every day I feel grateful."

Except for the research study, which is paid for under a grant, Medicaid has paid for all of Mr. Massey's care. "I'll put it this way," he says of Medicaid. "It takes a broken person and makes him feel whole." Without Medicaid, "people like me wouldn't have a chance."

Helping People Who Need Long-Term Care

Medicaid is the leading funding source for long-term care across the U.S., covering services such as nursing facility care for the elderly, residential care for people with developmental disabilities, and home-based assistance with the activities of daily living. To the greatest extent possible, the goal is to tailor care to fit each person's medical, social and physical situations.

■ **Flexible, cost-effective programs allowed 815 people to live at home instead of in institutions.** D.C. Medicaid operates two programs that fund home and community-based services (HCBS) for people who otherwise would have to live in institutions. Since this care costs less than institutional care, the federal government has waived otherwise-applicable rules so that beneficiaries can receive services designed for their specific needs. The HCBS program may pay for assistance with daily activities like eating and dressing, wheelchair ramps, a supportive living environment such as a group home, or occasional institutional care to give family caregivers a respite.

In FY 2005, the HCBS program for elderly people and people with physical disabilities served an average of 408 beneficiaries a month, up from 197 in FY 2004. These beneficiaries otherwise would typically be living in a nursing facility. The HCBS program for people with mental retardation and developmental disabilities served an average of 407 beneficiaries per month, an increase from 397 in FY 2004. These beneficiaries otherwise would be living in an intermediate care facility.

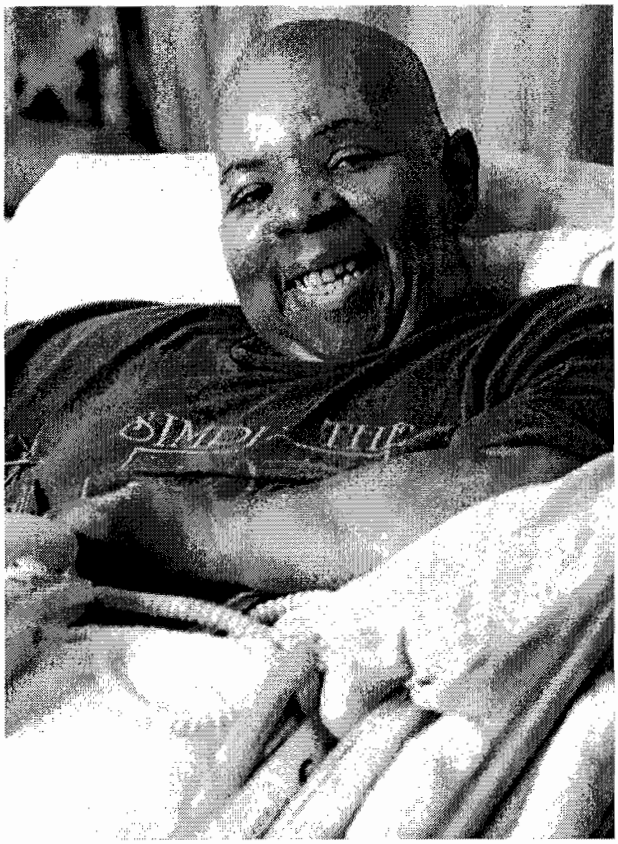
■ **Robert Wood Johnson grant will evaluate innovative D.C. program.** The prestigious Robert Wood Johnson Foundation awarded a grant to compare the Medical House Call Program (MHCP) with other ways of serving recipients of home and community-based services. The Medical House Call Program coordinates all home, hospital and community-based care through home visits to beneficiaries with chronic illnesses and limited mobility. (One participant is Mimi D. Atkins; see page 15.) The goal is to avoid unnecessary emergency room visits, hospitalizations, and nursing home placements. Results from the evaluation will help improve the program and potentially expand it. The evaluation grant will be managed by MAA and administered through a partnership that includes the Washington Hospital Center MHCP, Unity Health Care (a new house call program based on the Washington Hospital Center model), and the Delmarva Foundation, the quality improvement organization for D.C. Medicaid.

■ **New nursing facility payment method designed to boost access.** A new way of paying nursing facilities is intended to improve access to care and keep D.C. residents closer to home. Contingent upon federal approval, nursing facilities will be paid more for patients with greater care needs and less for patients with fewer care needs. Patient care needs will be measured using Resource Utilization Groups (RUGs), a clinical algorithm also used by Medicare and several other Medicaid programs. MAA's previous payment method was based on each facility's costs per day of patient care. These cost-based rates were capped and they didn't vary by patient, so patients with more expensive needs often had to be placed in facilities outside the District to get the care they needed.

■ **Consumer-directed care in home and community-based services.** A new initiative will give about 100 beneficiaries more flexibility in the home and community-based services they receive. Called "consumer-directed care," the initiative will give beneficiaries flexibility within a defined budget to decide which services they need to live as independently as possible. They will also have more involvement in selecting their personal care attendants and other caregivers. In FY 2006, consumer-directed care will become available to beneficiaries in the HCBS program for elderly people and people with physical disabilities.

■ **Improved access to services under the MR/DD waiver.** To improve access to home and community-based services for beneficiaries with mental retardation and developmental disabilities, MAA changed the rules to allow individual occupational therapists and speech/language pathologists to provide services. Previously, therapists had to be employees of an agency, which reduced the availability of providers.

Mimi D. Atkins



At first, Mimi D. Atkins didn't pay much attention to occasional back pain. It was the 1970s, and she was working at St. Elizabeth's Hospital as a nursing assistant, taking care of people with mental illness. But the pain got worse, and then her doctor said she had rheumatoid arthritis. It was a bad case. By 1979, she had to quit after 10 years at St. E's. As the illness progressed through the 1980s, she had both knees replaced, and she relied more and more on a wheelchair. By about 1990, the inflammation, deformity and pain in her joints meant she was bedridden.

Since the 1970s, BlueCross BlueShield insurance has continued to pay for her physician care, drugs, and occasional hospitalizations. But BlueCross, like virtually all commercial insurance plans, doesn't cover the costs of long-term care. Ms. Atkins's mother was her primary caregiver, turning her in bed, preparing her meals, bathing her and keeping her company.

In 2001, Ms. Atkins was hospitalized with blood clots, which typically form in leg veins and can be fatal if they break away and travel to the lungs. Hospital staff "talked to me about going to a nursing home until I got better. I said I didn't want to do it."

It was obvious that Ms. Atkins's mother, herself approaching 80, couldn't continue to care for her. Medicaid would pay for nursing facility care after Ms. Atkins exhausted her life savings, which, because of the cost of nursing facility care, usually doesn't take long. Instead, a doctor suggested Medicaid's program of home and community-based services (HCBS), which is designed to allow patients like her to stay at home as long as possible. Ms. Atkins applied for Medicaid and was accepted, but she wasn't yet old enough to qualify for the HCBS program. She was on a waiting list for over a year.

"I wouldn't be able to stay at home if it wasn't for Medicaid."

Today Ms. Atkins, now 60, and her mother still share one of D.C.'s classic brick row houses. Ms. Atkins's electrically controlled bed is in the former dining room. Family photos are on the living room mantle, and her mother sits on the porch to greet visitors and neighbors. Medicaid pays for a personal care aide 16 hours a day. The aide fixes her meals, bathes her, and turns her every two hours.

"I read, I have friends that call me every day, I have television of course, I talk to my aides and they talk to me, which is a godsend," she says. "I do a lot of things." Her lap is her desk, where she reads her mail and pays her bills. At night, she can press an alarm button to summon help or an ambulance if needed. She says she's doing well. "Life is what you make of it. I choose to be happy, the way I am right now."

Ms. Atkins also participates in an innovative program funded by Medicaid. Called the Medical House Call Program, its goal is to prevent unnecessary emergency room visits, hospitalizations and nursing facility placements. When a person can't walk, pressure sores, infections, blood clots and depression are constant threats to life, health and the ability to stay at home. Individual circumstances—how their home is arranged, how well they're eating, their activities—affect their physical and mental health. Under the Medical House Call Program, a nurse practitioner and a social worker, both specially trained, visit Ms. Atkins each month. A physician visits at least quarterly. They take 45 to 60 minutes to check her head to toe. Thankfully, and amazingly, she has had no problems with pressure sores. They also monitor her congestive heart failure, a serious illness that has been very well controlled.

"I wouldn't be able to stay at home if it wasn't for Medicaid," Ms. Atkins says. "They really help a lot, and I'm grateful for that. It's a blessing, really."

The D.C. Resource Center

Navigating the Maze of Long-Term Care Options

Resource center supervisor Angelique Calhoun assigns care managers to do individualized assessments of what's best for each individual.

When you can no longer live at home on your own, the options are baffling. Home health care, assisted living, nursing facility? Pay as you go, Medicare, Medicaid, private insurance? What's the difference? What's best for your situation?

Now, there's a one-stop answer. In January 2005, the D.C. Resource Center for Aging and Persons with Disabilities opened at 2311 Martin Luther King Avenue, near the Anacostia Metro stop. The public can drop in to the pleasant renovated home, call the center at 202-204-3540, or email inquiries to acalhoun@dcresourcecenter.com. A website is planned for the coming year.

About 100 people ask for help each month, and that number will grow as the word spreads. Sometimes the resident makes an inquiry; sometimes it is a family member or friend. They might learn about the resource center from its booth at a health fair or have been referred by a seniors' group or a health care provider. For some residents, life has changed suddenly because of a stroke or a fall; for others, they're just finding it harder and harder to live at home on their own.

A receptionist asks for basic information, then a professional staff member calls back within four hours. When appropriate, one of the center's three care managers will visit the home for a complete assessment, at no charge. "What medical conditions do you have? Can you walk on your own? Are loose rugs a hazard? Does a neighbor check in?" are typical questions.

Though placement in a nursing facility may be the best option for the resident, it's often possible for people to continue living in the community so long as they get a bit of help. Options include personal care attendants, skilled nursing care at home, modifications such as wheelchair ramps, or moving to an assisted living facility. Many of these services are covered by Medicaid's home and community-based services (HCBS) program.

To cut red tape, an eligibility worker from the D.C. Income Maintenance Administration is on site at the resource center. A resident can apply right there for Medicaid and the HCBS program. The eligibility worker even helps people apply for other D.C. programs such as food stamps and cash assistance for people with disabilities or families with children. When residents aren't eligible for Medicaid, care managers can advise them on other options such as Social Security, Medicare, subsidized housing and grant programs. At all times, the goal is to help residents navigate the maze of programs that might help them live as independently and as happily as possible.

Partnerships with Providers

In a typical month, 4,300 providers provide services to Medicaid beneficiaries—everything from a wheelchair van for a doctor's appointment to heart surgery at one of D.C.'s top hospitals. MAA and its contractors work to do a good job serving the providers who serve our beneficiaries.

■ **Managed care and fee-for-service.** For about 94,000 beneficiaries, Medicaid pays managed care plans, and then the plans pay physicians, hospitals, pharmacies and other providers. The other 48,000 beneficiaries are in "fee for service," where Medicaid is responsible for enrolling providers, setting payment rates, and processing claims.

Monthly Averages of Participating Providers

	FY 2003	FY 2004	FY 2005
Physicians	1,693	1,742	1,768
Pharmacies	181	181	191
Nurse practitioners	26	34	44
Dentists	19	20	23
Medical equipment & supplies	51	53	62
Transportation (excluding amb.)	146	152	182
Lab & X-ray providers	439	400	380

Note: "Participating" providers have billed Medicaid at least once during a one-month period.

■ **Rising participation rates.** A key measure of beneficiary access to care is the number of providers that serve Medicaid fee-for-service beneficiaries in a typical month. The table shows the provider types for which the participation rate is a good measure of access. (This rate is not as useful for hospitals, nursing facilities and other large providers that almost always serve some Medicaid beneficiaries each month.) MAA is pleased to report that participation rates have been rising for almost all provider types in the table.

■ **Increased electronic billing.** In FY 2005, MAA processed 7.0 million claims. The proportion of claims submitted electronically rose to 89% in FY 2005 from 77% the year before. The District's claims processing contractor turns around electronic claims within two days of receipt. Paper claims are keyed within an average of four days of receipt (a 19% improvement over FY 2004) and processed within two days after that. Providers are paid twice a month, in contrast to other Medicaid programs in this region that pay monthly. About 75% of payments are made by electronic funds transfer (EFT), up from 62% in FY 2004. EFT is significantly less costly for Medicaid than cutting paper checks.

■ **Increased communication with providers.** In FY 2005, MAA's claims processing contractor, ACS Government Healthcare Solutions, handled 84,899 phone calls from providers with an average answer time under 30 seconds. In addition, MAA and ACS increased their provider education efforts, which include quarterly newsletters, brochures on reducing billing errors and other topics, and over 300 face-to-face meetings with providers, in either individual or group sessions.

Medicaid's Economic Impact on the District of Columbia

Though Medicaid exists to improve the health of District residents, it's also important to the health of the D.C. economy.

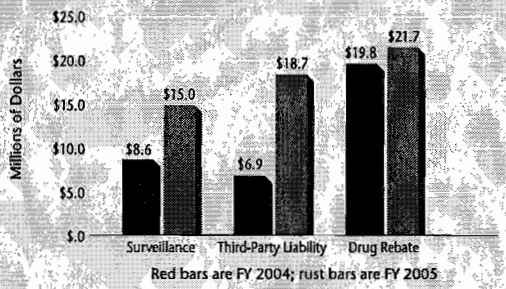
- First and foremost, providing health care to one-quarter of the D.C. population is essential to maintaining a healthy, productive D.C. workforce.
- 92% of the $1.22 billion that Medicaid spent on health care in FY 2004 was paid to D.C. providers. Of the remainder, 6% went to Maryland, 1% to Virginia and 0.5% to other states.
- Medicaid is the single largest source of federal funding to the D.C. government, bringing in about $900 million a year. Medicaid is cost-shared 30/70 between the two levels of government, so every D.C. Medicaid dollar is matched by $2.33 from the federal government.

Spending Dollars Wisely

Medicaid is the single largest spender in the D.C. government, with annual expenditures exceeding those of the K-12 public schools. Like all prudent purchasers, Medicaid seeks value for money—in this case, maximum health for the health care dollar. As a $1.26 billion program, Medicaid also inevitably attracts some providers intent on defrauding or abusing the program. This section describes initiatives related to value purchasing and program integrity.

■ **Fraud, waste and abuse recoveries rise 74%.** In FY 2005 MAA recovered $15.0 million as a result of efforts to protect against waste, fraud and abuse. Recoveries increased 74% over FY 2004. The surveillance and utilization unit and the investigations and compliance unit investigate possible overpayments to providers. These can reflect unintentional billing errors or conscious efforts to abuse or defraud the program. In FY 2005, for example, a physician, a dentist and a transportation provider were convicted of fraud. Five other cases are pending.

Across-the-Board Increases in Recoveries



Red bars are FY 2004; rust bars are FY 2005

■ **Third-party liability recoveries.** TPL recoveries were $18.7 million in FY 2005, more than double the previous year. Medicaid is the insurer of last resort, and the TPL unit recovers funds from other parties when they are liable for payments originally made by Medicaid. Third-party liability may exist when a beneficiary also has coverage from a commercial insurer, when a court holds a negligent driver financially responsible for injuring a Medicaid beneficiary, or when a deceased beneficiary's estate can pay for some of the care funded by Medicaid. In FY 2005, the TPL unit increased its efforts to recover money from third parties that were liable for care provided by Medicaid managed care plans. This effort paid off with a big increase in recoveries.

■ **Focus on cost avoidance.** Although TPL and fraud protection efforts bring in easily quantifiable recovery dollars, it is better practice to avoid the expenditures in the first place. In FY 2005, Medicaid tightened computer edits on the 250 most expensive physician services and on durable medical equipment, prosthetics, orthotics and supplies. Similar "cost avoidance" efforts in the future may well result in less need to recover dollars after the fact.

■ **Medicaid enrollees identification initiative.** In FY 2005, MAA implemented a new cost avoidance strategy to identify more Medicaid-eligible residents that are currently receiving public assistance paid by the District instead of through federal matching funds in the Medicaid program. MAA began conducting data matches to identify Medicaid-eligible students enrolled in the District's public schools, eligible recipients being assisted by the Department of Mental Health, and other eligibility shown on provider records.

■ **$21.7 million in revenue from drug rebates.** Drug rebate revenue rose 9.6% between FY 2004 and FY 2005. Rebates come from drug manufacturers under a federal law that requires that manufacturers always give Medicaid their best prices. To receive the rebates, Medicaid must meticulously track dosages on 1.2 million prescriptions a year and then defend the data to drug manufacturers. In a comparison of eight Medicaid programs, D.C. had the highest success ratio of rebates received to rebates invoiced.

■ **Plan to hire transportation broker.** In FY 2006, Medicaid will improve the organization of non-emergency transportation services, such as the wheelchair vans that take beneficiaries to medical appointments. Instead of dealing individually with each transportation provider, we will contract with a transportation broker to coordinate requests for service, supervise the service provided by individual transportation providers, and monitor providers for fraud. About 3,700 beneficiaries a month currently use these services.

■ **Plan to improve drug purchasing.** In FY 2006, we will take two steps to control drug expenditures while maintaining access to cost-effective drugs. First, we will follow the successful efforts of other Medicaid programs in using Maximum Allowable Cost (MAC) pricing for certain generic drugs. MAC prices more closely reflect actual marketplace prices than do the widely published Average Wholesale Prices or Federal Upper Limit prices. Second, we will implement a Preferred Drug List, which will increase competition among drug manufacturers for Medicaid's business.

■ **Plan to assess payment levels for health care.** In FY 2006, Medicaid will undertake a review of its payment levels for a wide range of services. Changes to payment levels are possible if such changes would make Medicaid a more effective purchaser of care.

■ **Payment Error Rate Measurement (PERM).** The District was awarded a federal grant to pilot test the PERM process that will be implemented nationwide in FY 2006. The pilot, which began in October 2004 and ended in September 2005, was designed to measure the accuracy of Medicaid payments using a sophisticated sampling methodology. It covered both the fee-for-service and managed care components and was designed to identify both payments that were too high and those that were too low. The pilot will yield important information to the District and will help the federal government develop final PERM regulations that are fair and accurate to Medicaid programs and providers.

■ **Partnerships with the private sector.** MAA uses a stringent competitive bidding process to hire experienced contractors to help it run the complex Medicaid program. In FY 2006, MAA expects to issue requests for proposals for four major contracts: the fiscal agent, which processes claims through the Medicaid Management Information System (MMIS); the pharmacy benefit manager, which administers the pharmacy claims payment system; the transportation broker described earlier in this section; and a decision support system (DSS). The DSS will be a new contract that will give Medicaid policy managers greatly increased access to the data necessary to manage the program.

How One Fraud Scheme Was Stopped

One individual probably thought he could make some easy money presenting fabricated prescriptions to pharmacies. He posed as a "runner" for a personal care home and said the prescriptions were for Medicaid beneficiaries. At one pharmacy, for example, he submitted 1,695 prescriptions in just three months. He used the name of a real physician (who was not involved) but a fictitious physician identification number. He was arrested for narcotics violations, pled guilty to a $1.4 million fraud scheme and was jailed.

And there the matter would have ended, except that federal and District investigators turned to the pharmacies that filled the fraudulent prescriptions. On July 28, the government announced that Chronimed Inc. had agreed to pay $475,000 to settle allegations that it submitted false claims. Investigations of other pharmacies are under way.[10]

Working for Medicaid Beneficiaries

A total of 121 people work for the Medical Assistance Administration, the lead agency for administering the D.C. Medicaid program. In this section we describe some of the work they do.

■ **Suprenia Robinson,** a program analyst in the Program Operations area, has worked with the Medicaid program for 15 years, first as a staff member for the claims processing contractor and then, since 2001, for MAA. "One of the reasons I've stayed with Medicaid so long," explains Suprenia, "is because I can help people. It's rewarding to know that during the course of my day, I've been able to help someone."

On average, Suprenia fields 60 to 80 calls each day from providers or social workers seeking authorizations for non-emergency transportation for disabled Medicaid beneficiaries. She also trains providers on how to submit claims accurately, resolves billing discrepancies, and processes provider appeals.

■ **Jeff Anderson** is a former U.S. Navy Search and Rescue aircrewman who joined MAA earlier this year as a public health analyst. "I wanted to continue to work in an environment where I could help people," says Jeff. "I certainly enjoy working with people who want help, but it makes me feel better working with those who need help."

Jeff largely focuses on implementing the District's home and community-based services (HCBS) program in support of the Real Choice Systems Change (RCSC) grant that MAA received from the federal government in September 2002. Jeff coordinates consensus-building meetings and works with a diverse group of stakeholders, including representatives of MAA's Office on Disabilities and Aging, the RCSC advisory committee, various subcommittees, beneficiaries, and providers to determine how best to serve the community.

■ **Elisa Fauntleroy** joined the Office of Managed Care as a program analyst and is one of seven staff members who works to ensure that the 93,000 Medicaid managed care beneficiaries have access to quality health care. Part of her job is to monitor MAA's contract with the District's four managed care plans.

Elisa also serves as the "go to" person when eligibility questions arise for managed care beneficiaries. She serves as a liaison with the D.C. Income Maintenance Administration (IMA), which determines Medicaid eligibility, and with the contractor that coordinates managed care enrollment. "When people have questions, I'm the person they can always reach," Elisa explains. "Nine times out of 9½ times, I can get it done. Resolving most recipient eligibility issues usually means a quick call to IMA, and we're able to resolve the issue usually within 24 hours. All you have to do is get on the phone and talk to the right person."

■ **Gwendolyn Bell**, a physician assistant, plays a key role in spearheading MAA's quality management and in managing the prior authorization review process. Daily, Gwen fields more than 60 calls from providers requesting authorization for unusual, expensive or medically complex services. She monitors the integrity of the medical records review process and helps to develop state plan amendments, among her many efforts to promote better quality and access to health care. After Hurricane Katrina, Gwen was one of several MAA employees who provided care to evacuees housed at the D.C. Armory. She cancelled her vacation days to do it.

While the pace of Gwen's job is fast, ultimately it's the satisfaction of helping someone that makes it worthwhile. As she explains, "They're so appreciative once you've helped them resolve the issue, and that makes all the difference. Hearing a 'thank you' for solving their problems is what keeps me going."

■ **Diallo "Abe" Bennett** joined MAA in 2001 as chief of investigations to reduce fraud and protect the integrity of public funds administered by Medicaid. With 20 years as a detective in the New York Police Department, as the former chief of the fraud unit in the Georgia Medicaid program, and with a wealth of experience in security management at private firms, Abe came very well prepared.

"I love my job and I feel I can help people—people who are probably in the least fortunate position," explains Abe. His unit's main goal is to "pay the right amount to a legitimate provider for covered, reasonable, and necessary services provided to eligible recipients."

Though Abe's job involves knowing about criminals, it also requires him to understand the intricacies of health care coding and billing, since this is how fraud gets perpetrated. He also believes in the importance of prevention, educating providers on how to avoid errors.

In August 2005, the U.S. Attorney for D.C. commended Abe for his contribution to the successful resolution of a case that recovered $475,000. (See page 19.) The federal Centers for Disease Control and Prevention has also asked Abe to help write a policy manual on combating fraud in the Vaccines for Children Program.

■ **Milka Shephard**, a program specialist, joined Medicaid 16 years ago, and now reports to the Medicaid director. Her job is to make sure that requests for information from beneficiaries, other D.C. agencies, the federal government, providers and community-based organizations are handled promptly through either the director or one of his staff. As Milka puts it, "I want things done to the best of my abilities in a timely manner."

Milka often uses her bilingual skills to field inquiries from Spanish-speaking beneficiaries. "While we can refer non-English speaking beneficiaries to Language Line services for assistance when they call, if they speak Spanish, it's easier for me to find out what they need and help them," she says. "I always put myself in their shoes. What if it was me? I'll do whatever it takes to help someone because I love what I do."

Understanding Medicaid Finances

Medicaid is a highly complex program that funds a very wide range of health care services in accordance with numerous federal and District statutory, regulatory and policy provisions. In this section we explain the D.C. Medicaid budget and some of the factors that drive it.

MEDICAID SPENDING IN CONTEXT

In FY 2005, spending for care was $1.26 billion (preliminary data), a 3.4% increase from FY 2004. The increase reflects a 2.1% increase in average monthly enrollment and a 1.3% increase in average monthly spending per enrollee. By contrast, the average cost of an employment-based family insurance plan rose 9.2% from 2004 to 2005, according to the September/October 2005 issue of *Health Affairs*.

The federal government pays 70% of the total and District taxpayers pay 30%.

The table on this page presents an overview of spending by responsibility center for FY 2004 through FY 2006, while the table on page 23 offers insight into detailed spending patterns in FY 2004. In a typical month, for example, there were 7,609 beneficiaries who received at least one physician service during the month. For these 7,609 recipients, Medicaid spent $187 per person per month, on average.

In reviewing the detailed spending data, three points should be kept in mind. With very minor exceptions, all Medicaid spending for managed care enrollees is shown in the "insurance premiums" category. Second, care provided under waiver programs (for example, most personal care) is shown under the "waiver" category. Third, spending totals under other categories (especially physician and hospital) include spending both on beneficiaries for whom Medicaid is the primary payer, and on beneficiaries for whom Medicaid is the secondary payer behind Medicare.

The D.C. Medicaid Budget

Responsibility Center	Actual FY 2004	Preliminary FY 2005	Budgeted FY 2006
Disproportionate Share Hospital Payments (6020)	$ 40,566,000	$ 40,188,012	$ 41,086,606
Day Treatment (6030)	27,291,000	26,530,713	27,326,634
Inpatient Hospital (6050)	249,270,000	272,787,923	280,971,561
Outpatient Hospital (6060)	25,007,000	19,276,729	20,047,798
Insurance Premiums (6070)	289,754,000	305,689,430	317,917,007
Nursing Facilities (6140, 6080)	182,048,000	176,977,991	186,769,173
Intermediate Care Facilities for the Mentally Retarded (6110)	77,317,000	78,405,445	81,613,033
Physician Services (6120)	17,053,000	18,389,101	19,124,665
Residential Treatment (6130)	13,089,000	14,033,602	14,594,946
Vendor Payments (6150)	162,754,000	169,731,140	183,512,970
Cost Settlement (6160)	11,300,000	22,977,417	22,977,417
St. Elizabeth's Hospital (6170)	34,559,000	25,956,923	42,381,548
D.C. Public Schools (6180)	19,636,000	19,375,879	22,258,552
D.C. Child & Family Services (6190)	48,736,000	41,960,556	38,322,831
Waivers	22,655,000	30,143,548	38,293,010
Subtotal Payments for Care	**$ 1,221,035,000**	**$ 1,262,424,409**	**$ 1,337,197,753**
MAA Administration (6010)	30,704,000	36,737,155	38,904,904
TOTAL	**$ 1,251,739,000**	**$ 1,299,161,564**	**$ 1,376,102,657**
Average Enrollees per Month	139,021	141,941	144,922
Average Spending per Enrollee per Month	$ 732	$ 741	$ 769

Notes

1. The fiscal year runs from October 1 through September 30. Expenses are tallied on an accrual basis.

2. FY 2005 numbers are preliminary data as of September 2005.

3. FY 2006 enrollment figure assumes a continuation of the growth rate seen between FY 2004 and FY 2005. It is not an official MAA projection.

4. "MAA administration" excludes other costs of administering Medicaid, such as the cost of eligibility determination borne by the Income Maintenance Administration.

Behind the Numbers: Detail of Medicaid Spending, FY 2004

Responsibility Center	Actual FY 2004	Average Spending per Month	Average Recipients per Month	Average Spending per Recipient per Month
Disproportionate Share Hospital Payments (6020) *Supplementary payments to hospitals that serve a disproportionate share of Medicaid and uninsured patients*	$ 40,566,000	$ 3,380,500	N/A	$ N/A
Day Treatment (6030) *Day treatment programs for people with mental illness*	$ 27,291,000	$ 2,274,250	1,241	$ 1,833
Inpatient Hospital (6050) *Payments to acute-care hospitals for inpatient care*	$ 249,270,000	$ 20,772,500	1,953	$ 10,636
Outpatient Hospital (6060) *Payments to acute-care hospitals for outpatient care*	$ 25,007,000	$ 2,083,917	6,763	$ 308
Insurance Premiums (6070) *Mostly payments to managed care organizations. Also includes some payments by Medicaid of Medicare premiums.*	$ 289,754,000	$ 24,146,167	100,718	$ 240
Nursing Facilities (6140, 6080)	$ 182,048,000	$ 15,170,667	2,900	$ 5,232
Intermediate Care Facilities for the Mentally Retarded (6110)	$ 77,317,000	$ 6,443,083	656	$ 9,828
Physician Services (6120)	$ 17,053,000	$ 1,421,083	7,609	$ 187
Residential Treatment (6130) *Non-hospital inpatient care for people with mental illness.*	$ 13,089,000	$ 1,090,750	124	$ 8,779
Vendor Payments (6150)	$ 162,754,000	$ 13,562,833		
Pharmacy (retail)	101,071,000	8,422,622	19,058	442
Home health care	22,357,580	1,863,132	1,153	1,616
Medical transportation (e.g., wheelchair vans)	18,769,674	1,564,140	4,016	389
Federally qualified health centers	2,395,628	199,636	1,020	196
Durable medical equipment	9,680,493	806,708	2,469	327
Personal care (assistance with activities of daily living)	597,000	49,750	63	786
Mental health clinics	4,801,000	400,083	N/A	N/A
Lab & x-ray (facilities separate from hospitals and clinics)	3,853,000	321,083	3,967	81
Private clinics	10,223,341	851,945	855	996
Hospice	1,427,154	118,929	29	4,073
Dental	766,000	63,833	335	190
Other vendor payments (e.g., optometrist, rehabilitation)	6,591,664	549,305	N/A	N/A
Drug rebates	(19,780,000)	(1,648,333)	19,058	(86)
Cost Settlement (6160) *Net impact of retroactive payment adjustments due to cost report settlements for providers paid based on their costs.*	$ 11,300,000	$ 941,667	N/A	N/A
D.C. Mental Health & St. Elizabeth's Hospital	$ 34,559,000	$ 2,879,917	3,257	$ 884
D.C. Public Schools (6180) *Payment to DCPS for health services provided to students enrolled in Medicaid, typically for students with disabilities.*	$ 19,636,000	$ 1,636,333	2,301	$ 711
D.C. Child & Family Services (6190) *Payment to CFS for health services provided to clients enrolled in Medicaid, typically for managing care for people with disabilities.*	$ 48,736,000	$ 4,061,333	2,676	$ 1,518
Waivers *Innovative programs operated under waivers from the federal government.*	$ 22,655,000	$ 1,887,917	1,473	$ 1,282
TOTAL SPENDING FOR CARE	$1,221,035,000			

MEDICAID ADMINISTRATION

The Medical Assistance Administration (MAA) is the lead agency for administering the Medicaid program. MAA spending on Medicaid administration in FY 2005 is projected to be $36.7 million. This figure includes both the salaries of Medicaid staff and payments to contractors, such as those that process Medicaid claims, respond to provider inquiries and perform related functions. The number excludes the costs of other D.C. agencies that help administer Medicaid, such as the Income Maintenance Administration, which determines eligibility. Even when all administration costs are totaled, however, Medicaid is still much less expensive to administer than commercial insurance, where the cost of administration averages 13.6% of spending, according to CMS.[11]

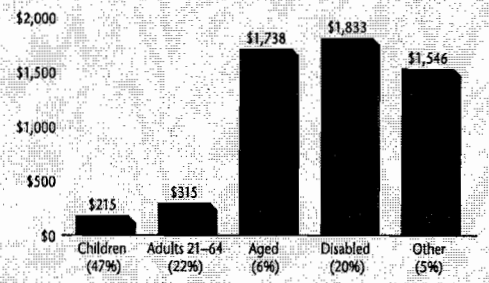
PATTERNS OF SPENDING

Medicaid spending is highly correlated with the type of eligibility a beneficiary has. On average, spending is relatively low for children and for non-disabled adults aged 21-64 (most often, the child's mother). Their health needs are similar to those of a commercially insured population, except with more emphasis on obstetrics and pediatrics. The 96,000 people in these two categories account for 69% of Medicaid enrollment but just 24% of Medicaid spending. They are primarily enrolled in Medicaid managed care plans.

On the other hand, spending is relatively high for people aged 65 or more and for people with disabilities. For some of these beneficiaries, Medicare covers their acute care costs, such as physician care and hospital stays. For dual eligibles, Medicaid usually pays their Medicare cost-sharing obligations (deductible, coinsurance, premiums) and these costs may be significant. And for some people in these groups, Medicaid is their only source of acute care coverage.

Most important, beneficiaries in these groups rely on Medicaid to cover the cost of long-term care, such as long stays in nursing facilities and home and community-based services that enable the beneficiary to avoid institutionalization. Overall, the aged, disabled and "other" categories (which mostly include people in waiver programs) represent 31% of Medicaid enrollment but 76% of Medicaid spending.

Spending per Month by Eligibility Category



For example, children represent 47% of total enrollment.

Notes

1 Jon Gabel, Gary Claxton, Isadora Gil and others, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.

2 Sara R. Collins, Karen Davis, Michelle M. Doty, and Alice Ho, *Wages, Health Benefits, and Workers' Health*, Issue Brief No. 788 (New York: The Commonwealth Fund, October 2004).

3 Estimates were made by ACS Government Healthcare Solutions based on Medicare and Medicaid administrative data and the 2002–03 Current Population Survey as analyzed by the Kaiser Family Foundation. (See www.statehealthfacts.org.)

4 Kaiser Commission on Medicaid and the Uninsured, www.statehealthfacts.org. The figures are for 2002–03.

5 FY 2005 spending totals are projections as of September 2005. Spending is accounted for on accrual basis, so final numbers may differ from the projections shown here.

6 Jon Gabel, Gary Claxton, Isadora Gil and others, "Health Benefits in 2005: Premium Increases Slow Down, Coverage Continues to Erode," *Health Affairs* 24:5 (September/October 2005), pp. 1273-80.

7 Stephen Heffler, Sheila Smith, Sean Keehan and others, "U.S. Health Spending Projections for 2004–2014," *Health Affairs*, Web Exclusives (February 23, 2005), p. W4-78; Stephen Heffler, Sheila Smith, Sean Keehan and others, "Health Spending Projections Through 2013," *Health Affairs*, Web Exclusives (February 11, 2004), p. W5-85.

8 For further information on HEDIS measures and NCQA accreditation, see www.ncqa.org.

9 U.S. General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations*, GAO/HEHS-00-149 (Washington, DC: GAO, 2000), p. 10.

10 U.S. Attorney for the District of Columbia, "United States Reaches $475,000 Settlement with a National Pharmacy Corporation to Settle Allegations that False Claims Were Submitted to Medicaid for Illegally Diverted Prescription Medications," news release, August 4, 2005.

11 Cynthia Smith, Cathy Cowan, Art Sensenig and others, "Health Spending Growth Slows in 2003," *Health Affairs* 24:1 (January/February 2005), p. 192.

For More Information

Information Need	Resource	Contact Information
Am I eligible for Medicaid? What do I do if my Medicaid card expires?	D.C. Department of Human Services, Income Maintenance Administration	202-727-5355 www.dhs.dc.gov
I can no longer live at home by myself. What are my options?	D.C. Resource Center for Aging and Persons with Disabilities	202-204-3540 info@dcresourcecenter.com 2311 Martin Luther King Ave. SE Washington, D.C. 20020
I have a question about my Medicaid benefits.	**Managed care:** Call your health plan. **Fee-for-service:** D.C. Medical Assistance Administration	**AMERIGROUP:** 800-600-4441 **D.C. Chartered Health Plan:** 800-408-7511 **Health Right:** 877-284-0282 **HSCSN:** 866-937-4549 **Fee-for-service:** 202-442-5988
I have a complaint about my Medicaid managed care plan.	Managed care complaint hotline	800-788-0342
How do I change from one managed care plan to another?	Managed care enrollment broker	202-639-4030
I want to report possible waste, fraud or abuse in Medicaid.	D.C. Medicaid Fraud Hotline	877-632-2873
I'm a health care provider. How do I enroll in Medicaid? How do I check whether my patient is eligible for Medicaid? What if I have a question about a claim I submitted?	ACS Government Healthcare Solutions (fiscal agent for D.C. Medicaid)	**Provider enrollment:** 202-906-8318 **Eligibility verification:** 202-610-1847 **Other inquiries:** 202-906-8319
I'm a health care provider. How do I obtain prior authorization for services?	**Pharmacy:** First Health Services **Other:** D.C. Medical Assistance Administration	**Pharmacy:** 804-527-5757 **Other:** 202-442-9115
How do I get a job at MAA?	D.C. Office of Personnel	202-671-1300
I'm a policy analyst or journalist with questions about Medicaid policy or budget.	Office of the Medicaid Director	202-442-5988
All other inquiries.	D.C. Medical Assistance Administration	202-442-5988 Room 5135 825 North Capitol St., NE Washington, D.C. 20002 www.doh.dc.gov

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Government of the
District of Columbia
Anthony A. Williams, Mayor

TAB L

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or to the Foreign Editors in the countries concerned.

Development of Birth Registration and Birth Statistics in the United States

By S. Shapiro

The development of adequate national birth statistics in the United States is closely linked with the long and difficult task of establishing effective registration systems throughout the country. The registration of vital events has always been under the authority of State and local areas. For many years, the formation of registration systems progressed independently in various States with virtually no unifying force present. It was not until the early part of this century that national standards for the registration of births were recommended. The voluntary adoption by the States of the major features of these standards has made it possible for the Federal Government to collect, tabulate, and publish an annual series of national birth statistics.

The historical movement for sound registration systems in the United States and the formation and growth of the national birth-registration area are briefly reviewed in this paper. A major portion of the article is devoted to nation-wide tests of birth-registration completeness. The final section discusses national statistics derived from birth records.

I. Developments prior to 1900[1]

Registration

The history of the registration of vital events in the United States dates back to early colonial days. In 1632, the Grand Assembly of Virginia required ministers or wardens from every parish to present themselves annually at court on 1 June to provide a register of all burials, christenings and marriages. Several years later (1639), the Massachusetts Bay Colony passed a law which marked a departure from past practice by requiring government officers to record births, deaths and marriages instead of the ecclesiastical ceremonies of baptisms, burials and weddings. This formed the pattern for the laws adopted by Connecticut and New Plymouth, and as time went on, other colonies placed similar measures into effect.

These acts were found to be ineffectual, and additional regulations were passed to fix the responsibility for registering vital events. In 1692, Massachusetts enacted what proved to be the most comprehensive registration law of the period. Important features were the reinforcement of an earlier penalty clause (1644 law) against the next of kin for failure to register a birth or death and authorization of town clerks

[1] Much of the material in this section is based on an unpublished report prepared by Mr Jack Ogus, Bureau of the Census. For further discussion of the early development of registration in the United States, see: Cressy L. Wilbur, *The Federal Registration Service of the United States: Its Development, Problems, and Defects*, Government Printing Office, Washington, D.C., 1916; John W. Trask, *Vital Statistics*, Government Printing Office, Washington, D.C., 1914; R. R. Kuczynski, 'The registration laws in the colonies of Massachusetts Bay and New Plymouth', *J. Amer. Statist. Ass.*, vol. VII, no. 51, September 1900; Walter F. Willcox, *Studies in American Demography*, chapters 4, 13, 17, Cornell University Press, Ithaca, New York, 1940.

to collect sixpence for a 'fair certificate' issued to anyone desiring such a record. Despite the relatively stringent regulations, important deficiencies still existed in the registration system.

It was more than 100 years later, in 1795, when the next significant step was taken toward promoting complete registration, with Massachusetts again being the innovator. The law, in addition to requiring parents to notify the town clerk of the births and deaths of children, made householders responsible for reporting births and deaths that occurred in their households, and institutions for those occurring in them.

Progress in other parts of the country was slow. This was not entirely surprising, since until the early 1800's practically the entire justification for maintaining a registration system was the legal and historical use that could be made of the records. Registration did not seem very important to a population undergoing rapid changes through immigration and subsequent migration within the country.

With the growing realization of the importance of vital statistics (particularly data on death) for health purposes, a new impetus was given to the establishment of strong registration systems. In 1841, Massachusetts passed what has been termed the first State registration law of modern type. Major advances made by this law (as revised in 1842 and 1844) were the provision for uniform certificates to be used throughout the State, and the establishment of a state-wide file of copies of the records. In addition, specific steps were taken to reinforce the authority of the registration system.

For the first time, national organizations took a direct interest in registration. In 1847, the American Medical Association during the initial year of its organization appointed a committee to study ways and means of improving the registration of births, deaths and marriages. Several years later, the Association formally urged physicians throughout the country to request their States to establish offices for the collection of vital statistics.

A number of States acted in rapid succession, and by 1859, eight had established registration systems. The Civil War halted the progress of such legislation, but it was resumed almost immediately afterwards, with each State substantially taking its own course. In some States it was necessary to report births within 30 days after the occurrence, whereas in a few areas, reporting was on an annual basis. Responsibility for filing birth certificates was not uniform, although the new concept of requiring the attendant at birth to file the certificate was gaining acceptance. Furthermore, the content of the birth certificates varied, and the legal status of the registration system in many areas remained weak.[1]

Statistics

Statistical reporting of births and deaths by States followed the centralized collection of the original certificates or certified copies of the records. The earliest reports were issued in Massachusetts.[2] The accuracy and reliability of the data, however, were seriously questioned by the officials themselves. It was not uncommon

[1] John S. Billings, 'The registration of vital statistics', *Amer. J. Med. Sci.* New Series, vol. LXXXV, pp. 33–59, 1883.

[2] *Massachusetts State Registration Reports*, The Office of the Secretary, Commonwealth of Massachusetts, 1841–3.

to find in some communities that very few or no birth records at all were filed for the entire year. With the passage of time, the situation improved in Massachusetts and other States, but a marked degree of under-registration continued to be the rule rather than the exception.

The inadequacies of the registration system fixed attention on the decennial census of the population as a means for collecting facts concerning vital events. The Constitution had provided for a regular periodic enumeration of the inhabitants of the United States for the purpose of apportionment of representatives in Congress and direct taxes. It was recognized very early that the census offered a unique method for obtaining additional useful information about the population, and the first census (1790) showed some slight expansion of the original plan.

In 1800 two groups unsuccessfully urged Congress to broaden the field of the census to a much larger number of facts than had been obtained in 1790. One of the memorials submitted was signed by Thomas Jefferson, then president of the American Philosophical Society. It included a suggestion that the number of births occurring during the previous year be enumerated and tabulated. The special birth tabulation was advocated as a means of distinguishing between the population increase due to births and that due to immigration, and also to serve as a component in the construction of an American life table.[1]

The first effort to collect national vital statistics, through the census method, occurred in 1850. Major emphasis was placed on obtaining mortality statistics, but tabulations were prepared showing the number of enumerated children who were under 1 year of age as of census date. No correction of State data was made for infants who were born during the year preceding the census but who had died prior to the date of enumeration. An adjustment for the country as a whole, which took this factor into account, was based on a special study in one State of reported infant deaths.[2] The United States crude birth rate was estimated at 28 per 1000 population, as compared with the uncorrected rate of 27. Even the higher figure cannot be taken as representing the actual birth rate for the period, in view of the marked under-enumeration of children less than 1 year old that undoubtedly occurred, and the failure to report many infant deaths.

A different adjustment was made in the 1860 count of infants under 1 year of age to arrive at a total birth figure for the United States. It was found that, during the year, births registered in two States, Connecticut and Massachusetts, totalled 11·7% more than the number of infants enumerated. This figure was arbitrarily raised to the ratio one-eighth, to correct for under-registration, and applied to the enumerated population less than 1 year of age. The crude birth rate was then set at about 33·5.[3] However, this is probably an understatement, since the basis for the correction factor assumes a higher degree of registration completeness in the two States than

[1] Carroll D. Wright and William C. Hunt, *History and Growth of the United States Census*, 1790–1890, pp. 18–20, Government Printing Office, Washington, D.C., 1900.

[2] U.S. Census Office, *7th Census*, 1850, 'Statistical view of the United States', p. 57, A. O. P. Nicholson, Public Printer, Washington, D.C., 1854.

[3] U.S. Census Office, *8th Census of the United States*, 1860, 'Population, Statistics of Birth', p. xxxviii, Government Printing Office, Washington, D.C., 1862.

would appear justified. It is also questionable whether enumeration completeness in the two States could be taken as the average for the entire country. The 1870 census made no further progress in arriving at a close estimate of the crude birth rate, although a careful study was made to determine the extent of underenumeration of infants and errors in reporting age of infants.[1]

In 1880 enumerators were required for the first time to determine the number of infants who were born and had died in the year preceding the census. This figure, added to the population under 1 year of age, resulted in a birth rate of 31. The method was repeated in 1890 and 1900, giving birth rates of about 27 for each year. Underenumeration and incorrect age classifications continued to be strong deterrents to the acceptance of the data as reliable.[2] Working from the population increase and allowing for deaths and immigration led to estimates of average annual crude birth rates for the United States that were much higher than those determined from enumeration data (e.g. the rate was 36 for the decade 1870–80 and 35 for 1890–1900).

After the 1900 census, all attempts to obtain vital statistics through the enumeration method were completely abandoned.[3] This came as the culmination of careful experimental work which had started with the 1880 census. Activity was centred around two approaches for improving mortality statistics.[4] Deaths rather than births were the focus of attention because of their direct relationship to health problems and the greater possibility of controlling the registration of such events.

Prior to the 1880 census, 'registers of deaths' were mailed to physicians throughout the country. The physician was asked to specify the place of death, date of death, various identifying items concerning the deceased, and the cause of death, covering deaths that occurred in the year preceding the census. Nation-wide publicity campaigns and appeals to medical associations requesting co-operation helped to secure a return of about 37% of the registers. It was found that, of the 167,000 deaths reported, 61,000 had not been enumerated. These were added to the census returns to make the statistics more complete.

The other experimental approach involved the use of death records filed in the States of New Jersey, Massachusetts, the District of Columbia, and nineteen cities as substitutes for the enumerators' collection of information concerning deaths. The crude death rate for this area was 19·8 per 1000 population, as compared with a rate of 13·5 obtained by enumeration for the rest of the country. In the 1890 census, death records in eight States, the District of Columbia and eighty-three cities outside the States were used in this manner.

[1] U.S. Census Office, *9th Census of the United States*, 1870, vol. II, 'Vital Statistics', pp. 515–24, Government Printing Office, Washington, D.C., 1872.

[2] U.S. Census Office, Government Printing Office, Washington, D.C.: *10th Census of the United States*, 1880, vol. XII, 'Mortality and vital statistics', part II, p. cxl (1886); *11th Census of the United States*, 1890, 'Vital and Social Statistics in the United States', part I, Analysis and Rate Tables, p. 481 (1896); *12th Census of the United States*, 1900, vol. III, 'Vital Statistics', part I, Analysis and Ratio Tables, pp. xlix–lv (1902).

[3] Lack of confidence in the reliability and completeness of vital statistics collected through the enumeration procedure had been expressed by census statisticians as early as 1850. The method was used as the alternative to having no data at all.

[4] U.S. Census Office, *Mortality and Vital Statistics of the United States*, part I, 1880, pp. xi–xxiii, Government Printing Office, Washington, D.C., 1885.

Encouraged by the results of these experiments, the Census Office surveyed all States and each city of 5000 or more population shortly before the 1900 census to determine the adequacy of their registration systems. Completeness of death registration was measured for many of these States and localities by comparing names on the enumerators' schedules against the files of registered deaths. Although registration was found 'satisfactory' in only a few States, the prospects for rapid improvement in the situation seemed better than ever before. It was inevitable that birth registration and statistics should also benefit from many of the events that followed.

II. The national birth-registration area

Events immediately preceding formation

Years of discussion and agitation finally resulted in a quick succession of actions with far-reaching effects on the development of national vital statistics. The foremost was the establishment of the Bureau of the Census as a permanent office in 1902. Certainly, one of the strong deterrents to the Federal Government's participation in promoting vital registration had been the absence of a permanent agency which could maintain continuous interest in the subject. The Census Office was responsible for the collection and analysis of national vital statistics, but its span of life was long enough only to plan, conduct and publish the results of each census.

In forming the permanent Bureau of the Census, Congress provided for the collection of statistics on births and deaths in registration areas annually. The Director of the Bureau was authorized to obtain data from registration records of such States and cities as, in his discretion, could provide satisfactory data. The attitude of the Bureau towards State and local organizations which had been expressed a little earlier was unchanged: 'It (i.e. the Census Office) cannot direct or control local officers, nor dictate the methods to be employed; it can only advise and assist in the matter (of effective registration), and crown the movement with final success by making its published statistics as useful as possible.'[1]

The next step taken by Congress was to adopt a resolution in 1903 which stressed the importance of a complete and uniform system of registration throughout the country. Favourable consideration and action of State authorities were requested. The resolution stimulated widespread discussion and facilitated census plans already initiated for obtaining uniform vital statistics.

In preparation for the decennial collection of mortality statistics in 1900, the Bureau had obtained copies of State laws, municipal ordinances, forms and instructions governing vital registration. A comprehensive study of the materials placed the inadequacies of many of the laws in sharp relief. The next order of business was to formulate the requirements for sound registration practices and adequate legislation. For this task, the Bureau joined forces with the Committee on Demography and Statistics of the American Public Health Association which had also been considering the problem. Their recommendations included a basic set of principles to guide States

[1] U.S. Census Office, *Registration of Deaths*, Vital Statistics Circular no. 71, p. 2, Washington, D.C., 1902.

in preparing laws for the registration of deaths and the collection of mortality statistics. An integral part of the circular containing the principles was a standard certificate of death which it was hoped the States would use as a basis for revising their certificates. Copies of the circular were sent to the Governor of each State, medical societies, journals and others interested in effective registration. The document was then extended to cover the registration of births and a standard certificate of birth was issued.[1]

The need for more specific guidance to the States in preparing legislation soon became apparent. Broad principles were not enough, and through the joint efforts of the Census Bureau, American Medical Association, American Public Health Association and other organizations there emerged in 1905 a working draft of the Model Law.[2] As the name implied, this 'law' was designed only as a model for legislative action in the States, but behind it was the force of many national and State groups. The Model Law clearly specified the central authority of the State boards of health over registration matters, provided for the establishment of a strong local apparatus, fixed responsibility for registering births on the attendant at birth (physician, midwife), called for rigid enforcement of the law, and listed a minimum set of items for inclusion on State certificates.

The first test of the adequacy of the recommended bill occurred in Pennsylvania, which passed a law in 1905 patterned after the Model Act. Striking improvement in birth and death registration was almost immediately apparent. This success led several other States shortly thereafter to adopt similar Acts, or to amend existing laws to conform to it.

The Bureau of the Census, while co-operating with various organizations on the legal aspects of registration, was also conducting an energetic campaign to increase the coverage of the recently formed death-registration area. The prerequisite of 90% completeness for admittance had been established, and considerable prestige was associated with being part of the area. Furthermore, the American Medical Association, the American Public Health Association, and many other groups were actively engaged in publicizing the importance of registering all deaths. Between 1900 and 1915, the death-registration area increased from ten States and the District of Columbia to twenty-four States.

Steps were taken to create a birth-registration area several years before the 1910 census. For the calendar year 1908, the Bureau of the Census collected, from every possible source, transcripts of all births registered in the United States. The collection was believed to be almost exhaustive, but the birth rate based on these records was only 19·8 for the area making returns. Transcripts of births occurring in 1909 and 1910 were obtained from eight States, New York City, and the District of Columbia, where birth registration seemed to be most efficient. The birth rate for the area was 24·9 in 1909 and 25·4 in 1910.[3]

[1] Bureau of the Census, *Registration of Births and Deaths*, Vital Statistics Circular no. 104, Government Printing Office, Washington, D.C., 1903.

[2] A final draft was published in 1907. The Act underwent a basic revision in 1942 and was superseded by the Uniform Vital Statistics Act of that year. This is now being reviewed for necessary change.

[3] Cressy Wilbur, op. cit. pp. 18–19.

The huge task of conducting the 1910 census caused the Bureau to relax its efforts in forming a birth-registration area. Fortunately, other factors developed which tended to promote registration. Interest in reducing infant mortality in the United States was gaining momentum, and the need for accurate birth and death statistics to measure the problem became acute. In 1912, the United States Children's Bureau was created, one of its major responsibilities being the investigation of infant mortality. The new Bureau took the initiative and enlisted the support of a wide variety of organizations to help States improve registration. Not only were the statistical values of birth records receiving attention, but the personal value of the certificate itself increased. The birth record in some places became the primary document for verifying age in entering school and in obtaining work permits.

Despite the marked improvement in birth registration that followed these events, its status on a national scale in 1915 was described by leading statisticians of the day as very poor. It was recognized that the formation of a birth-registration area would act as a stimulus to further activity.

The expanding birth-registration area, 1915–1933

In 1915, the national birth-registration area (B.R.A.) was established by the Bureau of the Census. It consisted of the District of Columbia and ten States located in the north-eastern and north central parts of the country. The method used for judging which States were to form the area is not clear from available literature. However, all the selected States were among the first to enter the death-registration area, and they undoubtedly also represented the most developed areas from the birth-registration standpoint. Subsequent admittance to the B.R.A. was based on findings of objective tests. The same standard that was being used in the death-registration area (i.e. 90% registration completeness) was adopted. States already admitted were subject to re-testing, and the possibility of being dropped from the B.R.A. was always present.

By 1917, ten new States had been added to the B.R.A. Progress was much slower after this year, and the entire United States was included for the first time in 1933. Fig. 1 shows how the area's coverage spread from the urban north, across the mid-west and west, and finally through the rural south. This was the main pattern, although there were some exceptions. Generally the order of admittance to the B.R.A. was similar to the experience in the expanding death-registration area. In some cases, States were admitted to both areas during the same year. Table 1 indicates the number of States and the proportion of the United States population included each year in the B.R.A.

The effort that went into building the birth-registration area was very great. The Bureau of the Census, American Public Health Association, United States Children's Bureau and the Public Health Service maintained field representatives on a full-time basis in various States to assist them in establishing efficient registration systems. Newspapers, theatres, physicians and midwives were enlisted by State and local registrars to promote registration. Civic organizations of the most diverse types (e.g. Federation of Women's Clubs, Boy Scouts of America, American Legion)

participated in specific phases of the drive. Prominent persons and organizations were solicited for statements concerning the importance of birth registration for child welfare and public health purposes.

Table 1. *The expanding birth-registration area: United States*

Year	Estimated mid-year population of continental United States	Birth-registration States		
		No. of States	Estimated mid-year population	
			No.	Percentage of total
1933	125,578,763	48	125,578,763	100·0
1932	124,840,471	47	118,903,899	95·2
1931	124,039,648	46	117,455,229	94·7
1930	123,076,741	46	116,544,946	94·7
1929	121,769,939	46	115,317,450	94·7
1928	120,501,115	44	113,636,160	94·3
1927	119,038,062	40	104,320,830	87·6
1926	117,399,225	35	90,400,590	77·0
1925	115,831,963	33	88,294,564	76·2
1924	114,113,463	33	87,000,295	76·2
1923	111,949,945	30	81,072,123	72·4
1922	110,054,778	30	79,560,746	72·3
1921	108,541,489	27	70,807,090	65·2
1920	106,466,420	23	63,597,307	59·7
1919	104,512,110	22	61,212,076	58·6
1918	103,202,801	20	55,153,782	53·4
1917	103,265,913	20	55,197,952	53·5
1916	101,965,984	11	32,944,013	32·3
1915	100,549,013	10	31,096,697	30·9

Note. The area included the District of Columbia each year.

When a State office felt that its promotional activities had progressed far enough, the Bureau of the Census was requested to carry out a test of registration completeness. In the early years of the B.R.A., the test was based on names of newborn infants collected from a variety of sources such as newspaper listings, infant death records, school censuses, etc. The listing was accepted as a representative sample of births that occurred, and an attempt was made to match the names against the birth record file. If a State failed to meet the 90% criterion, provision would be made to concentrate on the more backward areas and a re-test given shortly afterwards.

A more systematic method for obtaining a list of newborn infants was adopted in the early 1920's. The new technique called for distribution of postcards to every household in the State via the postal delivery service. The family was requested to fill out the card if a child had been born during a specified period of time, usually the preceding year. If a State-wide distribution was not feasible, sample areas were covered. A widespread publicity campaign would usually precede the test to impress the community with the importance of co-operation in the survey.

The response rate in the postcard tests varied considerably from State to State, but returns usually totalled only between 30 and 50% of the number of birth records on file. However, the method was considered more accurate than any other procedure that could be devised at the time. Although all of the known biases were in

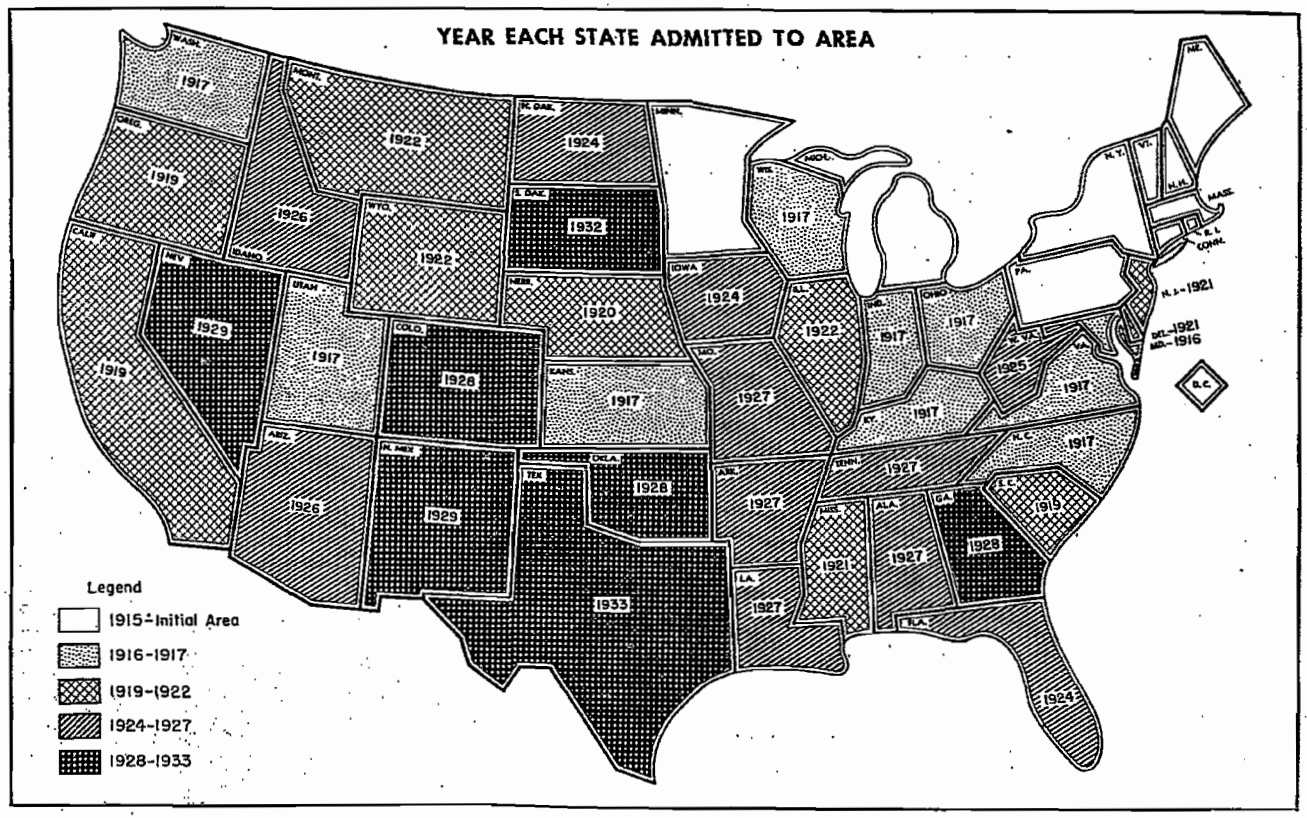


Fig. 1. Growth of birth-registration area: United States, 1915–33. Note: Rhode Island dropped from the area in 1919; readmitted in 1921. South Carolina dropped from the area in 1925; readmitted in 1928.

the direction of inflating the percentage of registration completeness, the results were considered sufficiently accurate to serve as a basis for admitting States to the area.

Some of the biases arose through selective distribution of the postcards. More inaccessible areas which did not receive mail frequently were the most likely to be missed in the survey. Furthermore, the response rate from the least literate portion of the population was lower than that for the others. As later tests showed, registration was less complete in these groups.[1] Another factor which served to inflate the completeness figure was the overlapping between publicity campaigns and the tests. Sometimes this made it possible for attendants to file birth records which they ordinarily would not have recorded.

Fortunately, the Bureau of the Census did not permit these problems to create an obstacle in testing and admitting States to the B.R.A. Otherwise, a substantial delay in completing the area would almost certainly have occurred. This, in turn, would have retarded some of the advances in registration practice and statistics achieved since 1933.

Following the completion of the B.R.A., the Bureau of the Census (Division of Vital Statistics) defined as its future responsibilities, the improvement of basic data and the broadening of research in the field of vital statistics. Methods for controlling the accuracy of information obtained through the birth record received greater attention (see Part IV). Furthermore, the Division's approach to the problem of registration completeness underwent a fundamental change:

'The need for new methods of testing completeness of registration is one of the most vital problems confronting the vital statistician. The future policy of the Division will be that the object of such checks will be to help the State in its problems of registration, rather than to threaten its removal from the registration area. Regardless of whether a State measures above or below the accepted standard of 90% registration completeness, all data should be published for scientific investigators, and the users of vital statistics may then correct the data for each State according to the relative completeness of the registration.'[2]

Activities directed at the solution of these problems have been joint enterprises between the Federal Government and the State offices of vital statistics. In more recent years, this has taken organizational form. The present structure is the Public Health Conference on Records and Statistics. Its membership includes representatives of the registration and statistical activities from State, territory and independent registration areas. The purpose of the Conference is to serve as a medium for the interchange of information and viewpoints, and for the development and promotion of procedures relating to all phases of public health statistical and record activities which are interstate and national in scope.

[1] A. W. Hedrich, John Collinson, and F. D. Rhoads, *Comparison of Birth Tests by Several Methods in Georgia and Maryland*, Vital Statistics, Special Reports, vol. VII, no. 60, Bureau of the Census, Washington, D.C., 10 November 1939.

[2] Halbert L. Dunn, 'Vital Statistics Collected by the Government', *Ann. Amer. Acad. Polit. Soc. Sci.* November 1936.

III. Completeness of birth registration in the United States

The 1940 test of registration completeness

Prior to 1933, the function of the tests of birth-registration completeness conducted by the Bureau of the Census was to determine whether a State met the 90% criterion for inclusion in the B.R.A. and to help plan campaigns to improve registration. As previously mentioned, the precision of the results was not very high, and tests administered in the various States differed greatly in time. It was therefore never possible to combine the results to secure a reliable picture of birth-registration completeness for the country as a whole.

The first uniform nation-wide birth-registration test in the United States was conducted in conjunction with the 1940 Decennial Census of Population and Housing. The primary purpose of the test was to obtain measures of registration completeness on a comparable basis for all States and minor sub-divisions. The results were expected to help registrars localize problem areas for registration promotion and to determine reasons for failure to register births.

Briefly, the procedure for carrying out the test was as follows:[1] During the Population Census of 1940, enumerators were instructed to fill out special infant cards for all infants who were born during the period 1 December 1939 to 31 March 1940, and who were alive on 1 April 1940. State offices of vital statistics provided copies of birth records for infants born during the same period and copies of death records for infants who were born and had died during the test period. The death records and infant cards formed the population against which birth records had to be matched. These totalled 687,457 records, of which 662,614 were infant cards and 24,843 were copies of death records.

Matching was based on varying combinations of common identifying items appearing on the records. In the initial stages, all but about 20% of the infant cards were matched. The 125,000 families represented by this residual group were sent letters requesting data needed to clarify or complete the unmatched infant cards. With the aid of a follow-up letter to non-respondents and hospitals, information was received for 75% of the group surveyed. Between one-quarter and one-third of the 125,000 unmatched infant cards were eliminated from the test because replies from the parents clearly indicated that the children were born outside the test period.

Following the mail survey, a field agent from the Bureau of the Census was sent to almost every State office with abstracts from the unmatched infant cards. With the assistance of State employees, a third of the corresponding birth records were located. The additional matches were made principally because of (*a*) greater familiarity of State employees with handwriting on records and searching problems, and (*b*) the availability of special files for adopted children, records from foundling homes, etc.

Final results of the test showed that birth registration was 92·5% complete throughout the country. Registration completeness was above 97·5% in eleven

[1] Robert D. Grove, *Studies in the Completeness of Birth Registration*, Bureau of the Census, Vital Statistics, Special Reports, vol. XVII, no. 18, 20 April 1943.

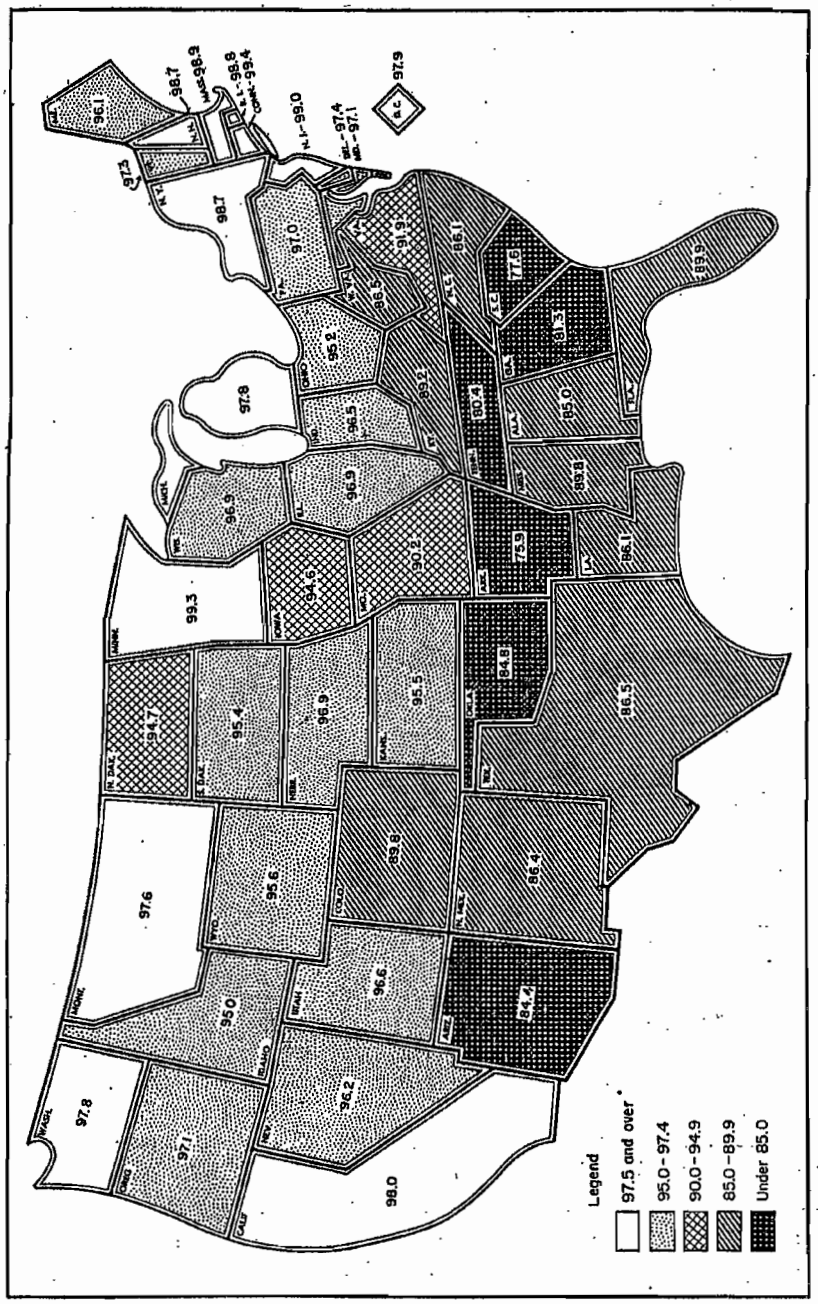


Fig. 2. Percent completeness of birth registration: each State, 1 December 1939 to 31 March 1940.

States, but it was below 90% in sixteen States. The percentage for each area was derived by relating the matched number of records to the total number of infant cards and death records in the area.

Fig. 2 indicates the variability in the degree of under-registration among the States. It is interesting to note that the States which had formed the original B.R.A. had high completeness records in 1940, and many of those which were admitted late still had very difficult situations to overcome.

The matched and unmatched sets of cards resulting from the test were also utilized to derive measures of registration completeness for a variety of characteristics. These tabulations were based on samples consisting of 20% of matched infant cards for white infants, 50% of the matched infant cards for non-white infants, and 100% of the unmatched infant cards for all races. The sample figures were expanded and adjusted to agree with recorded State totals by race determined from a hand count of the infant cards.[1]

Some of the statistical findings in the test are given below. Their significance is many-sided. In the first place, they point to the population groups in which registration is poor, and thereby help direct promotional and educational campaigns aimed at the attendants who serve them. In addition, it is of the utmost importance to establish which groups in a community would not be reached if the public health programmes were to depend exclusively on the birth record for control purposes. Efforts to cover an entire community are facilitated by a knowledge of the characteristics of families where under-registration is significant. Finally, the usefulness of regularly tabulated data for overall planning of school and hospital facilities, housing, etc., is increased by the availability of correction factors for under-registration.

Space limitations make it possible to present data in this paper only for the entire country, but comparable breakdowns are available for various geographic groupings of States, and, in some instances, for individual States. Except in the few cases noted, the percentages shown have relative sampling errors of less than 1%.

Registration completeness by:

(*a*) *Race.* In practically every section of the country, white births were much more completely registered than non-white. For the nation as a whole, the percentages in these two race groups were 94·0 and 81·5 respectively.[2] Similar differences between the race groups were found in all major classifications of the test data.

(*b*) *Urban-rural areas and occurrences in or out of hospitals* (Table 2). The test verified the hypothesis that under-registration was most severe among births occurring in rural areas, and also demonstrated that the problem decreased in successively larger urban areas. Of greater significance was the finding that most of these differences were considerably reduced when registration of births in hospitals or institutions was studied separately from that of births at home. Thus, while the absolute

[1] Special problems connected with unmatched infant death records made it advisable to exclude the entire group of infant deaths from the sample. This is estimated to have introduced only a very minor bias in the registration completeness figures.

[2] Registration completeness figures based on matched infant cards and death records were 94·0% for the white race and 82·0% for the non-white.

difference between the percentages of registration completeness for urban and rural areas as a whole was 9·5%, the urban-rural difference for events occurring in hospitals was only 2·0% and for occurrences not in hospitals 2·8%.

Table 2. *Percentage completeness of birth registration by race, urban-rural areas, occurrence in or out of hospitals: United States, 1 December 1939 to 31 March 1940*

(By place of occurrence)

Area	Total			In hospital			Out of hospital		
	All races	White	Non-white	All races	White	Non-white	All races	White	Non-white
United States	92·5	94·0	81·5	98·5	98·6	96·3	86·1	88·2	77·2
Urban	96·0	96·7	88·4	98·6	98·7	96·6	88·0	89·5	81·6
Places of:									
100,000 and over	97·7	98·1	94·3	98·9	99·1	97·0	90·7	91·2	88·9
10,000–100,000	96·0	96·8	86·5	98·7	98·7	96·2	88·3	89·7	82·0
2500–10,000	92·0	93·5	76·2	97·5	97·6	92·1	85·8	88·1	74·1
Rural	86·5	88·9	75·8	96·6	96·8	93·5	85·2	87·6	75·2

In the non-white group, close to 23% of the births occurring out of hospitals were unregistered. This was particularly serious, since about three in four of the non-white infants were born at home. Even in cities of 100,000 or more population, there existed a problem of under-registration of home deliveries affecting both white and non-white births. The test demonstrated that the registration of births occurring in hospitals could not be taken entirely for granted. Although the percentages for such occurrences were generally high, there was need for improvement, especially among non-white births in smaller cities and rural areas.

(*c*) *Age of mother* (Table 3). The completeness with which births to women in various age groups are registered has direct meaning for fertility analyses based on age-specific birth rates. The test showed that registration was more complete for the infants born to women 20–34 years of age than for those to older mothers or to very young women, 5·2% separating the high from the low.

A somewhat different picture is obtained when completeness figures for the

Table 3. *Percentage completeness of birth registration by race, age of mother, occurrence in or out of hospitals: United States, 1 December 1939 to 31 March 1940*

Age of mother	Total			In hospital			Out of hospital		
	All races	White	Non-white	All races	White	Non-white	All races	White	Non-white
All ages	92·5	94·0	81·5	98·5	98·6	96·3	86·1	88·2	77·2
Under 20	90·9	93·1	83·5	98·1	98·3	97·0	85·6	88·4	78·5
20–24	92·8	94·3	81·9	98·5	98·6	96·9	86·5	88·7	77·2
25–29	93·5	94·7	82·0	98·7	98·8	96·5	86·6	88·4	78·1
30–34	93·1	94·3	81·0	98·5	98·6	94·9	86·6	88·3	77·5
35–39	91·0	92·5	78·7	98·1	98·3	94·0	85·0	87·0	75·5
40 and over	88·3	90·6	70·9	96·9	97·1	92·7	83·0	86·1	67·3

non-white races are examined. In this group, the highest percentage was found for births to women under 20 years of age, and the difference between high and low percentages was substantial (12·6%). The difference was 4·1% in the white race.

The influence of place of birth (i.e. in or out of hospitals) on measures of registration completeness by age of mother is clearly demonstrated in Table 3. Births occurring in hospitals, regardless of age of mother or race, had a very high likelihood of being registered. The figures for births occurring at home were, of course, much lower.

(*d*) *Highest grade of school completed by mother* (Table 4). One of the most striking relationships to be found in the test was that between educational level of mother and birth-registration completeness. By far the poorest registration situation (79·3%) existed among births to women with less than 5 years of grade-school education. The corresponding proportion for the college group was 18·1% higher. Considering registration in each race group and in urban-rural areas separately reduced the completeness differential effectively only for urban residents. This probably could be traced to the more general use of hospitals for confinement among all groups in cities as compared with rural residents.

Another interesting feature of the data is the marked difference in registration completeness between the two races in all categories shown. Part of this might also be due to the 'in or out of hospital confinement' factor.

It will be noted in the table that the registration-completeness problem was more acute among the births to farm residents than among those to non-farm. This was

Table 4. *Percentage completeness of birth registration by race, urban-rural area: years of school completed by mother, United States, 1 December 1939 to 31 March 1940*

(By place of residence)

Area and Race	Total	Grade school			High school		College
		0–4 years	5–6 years	7–8 years	1–3 years	4 years	1 year or more
United States	92·5	79·3	85·1	92·4	94·6	96·8	97·4
White	94·0	82·7	87·3	93·4	95·3	97·0	97·5
Non-white	81·5	73·6	79·7	83·5	87·8	91·4	92·7
Urban	96·2*	88·4	91·7	96·0	96·7	97·9	98·0
White	96·9*	90·3	93·2	96·6	97·2	98·1	98·1
Non-white	89·8*	83·4	87·3	90·2	92·3	93·4	94·8
Rural	88·4*	75·1	81·5	89·3	91·6	94·9	96·3
White	90·6*	78·3	83·8	90·6	92·6	95·1	96·5
Non-white	75·7*	70·6	76·5	78·6	80·5	85·6	86·8†
Rural farm	85·6	72·6	79·4	87·7	89·6	93·7	95·5
White	88·6	76·1	81·9	89·3	91·0	94·1	95·9
Non-white	73·4	68·9	75·3	76·7	76·6	81·7†	81·1†
Rural non-farm	91·8	80·4	85·2	91·5	93·5	95·7	96·8
White	92·8	81·7	86·6	92·3	94·1	95·9	96·9
Non-white	81·6	77·2	80·1	82·6	85·6	89·3†	92·0†

* Differ from comparable figures in Table 2. The above data are by place of residence of child's mother; in Table 2, data are on a place of occurrence basis.

† Relative sampling error is 1% or more.

true for both the white and non-white groups and at each educational level. The worst situation of all (31% incompleteness) existed in the group of non-white births to farm residents with little or no education (i.e. under 5 years).

Errors in the 1940 birth-registration test

In any large-scale operation, situations inevitably arise which result in biases despite the most strenuous efforts to control them. The 1940 test was no exception, although the net effect of such biases is believed to have been minor. The nature of several sources of error and the direction in which they probably influenced the test figures are given below.

(1) The most important bias in the test arose from the fact that not all infants alive at the time of the census were enumerated. This would not have affected the test results if the missed infants were just as likely to have been registered as the children who were enumerated. But the more reasonable conclusion to draw was that some correlation existed.

In the absence of an opportunity to re-canvass selected areas, tables were prepared to determine the limits of the bias under certain assumptions of the degree of positive correlation between the unregistered and unenumerated events. A recent article by Drs Chandra Sekar and Deming[1] appears to present a more direct method for estimating this type of bias. The basic objective in the method is to sub-divide an area (either geographically or by a combination of characteristics) into sub-groups each of which is highly homogeneous with respect to enumeration completeness. In terms of the article, a completely homogeneous population would be one in which each event had an equal probability of being enumerated.

Within such sub-groups, the correlation between unregistered and unenumerated events would be very low. An estimate of the total number of registered and unregistered births in the area, approximating the unbiased estimate, could then be derived by cumulating the 'total number of births' corrected for under-registration in each sub-group.

This method was applied to data derived from the 1940 birth-registration test. For each State, comparisons were made between (1) the percentage of registration completeness derived from matched and unmatched records for the State as a whole, and (2) the percentage obtained by cumulating estimates of the total number of births (registered and unregistered combined) in minor civil sub-divisions of the State by race.[2]

The effect of cumulating sub-totals was to decrease the United States figure by

[1] 'A method of estimating birth- and death-rates and the extent of registration', *J. Amer. Statist. Ass.* vol. XLIV, no. 245, March 1949.

[2] In method (2), it was known how many white and non-white births were registered in individual cities of 10,000 or more population within each county of a State and in the balance of the county. Percentages of registration completeness available from the birth-registration test for each of these sub-groups were divided into the corresponding registered birth figures. The quotients represented estimates of the total number of births corrected for under-registration in specific sub-divisions of the counties. These were cumulated to obtain the total number of births for the State. Finally, the number of registered births in the State was divided by this figure. The result was taken as the new measure of registration completeness in the State.

0·7%. In practically all States with registration completeness of over 90%, the effect was minor. A difference of 1% or more between the two percentages occurred in only eleven States. The five States with differences of 2% or more had the lowest percentages of registration completeness in the country. In thirty-two States, method (2) gave a lower percentage of registration completeness than method (1). In only four areas were percentages based on cumulated figures higher than the others, with the largest difference being 0·3%.

(2) Incompleteness of infant death registration could introduce a bias in the same way as underenumeration; i.e. if independence is lacking between the filing of a birth and infant death record. While there is no evidence on the subject, it seems likely that a positive correlation exists. However, the effect of this relationship could not be very great for most sub-divisions of the country. This point may be illustrated as follows: 24,843 infant death records were included in the test. Under the assumption that under-registration in the group was 7–8%, there should have been an additional 1900 death records. If all of these represented unregistered births, the percentage registration completeness would have been reduced from 92·5 to 92·3%. A greater effect would be expected in those areas where the infant mortality rates were higher than for the country as a whole. But, even in such areas, unless the rate was unusually high, it could not introduce a very large relative bias in the completeness figure.

(3) Since it was planned to initiate the mail survey on unmatched infant cards during the summer of 1940, it was essential to reject all birth certificates filed after 31 July 1940. This deadline did not correspond with usual practice in accepting records from State offices for regular tabulations. December 1939 birth certificates were tabulated only if they had reached the Census Bureau by 1 June 1940. January–March 1940 certificates, however, were tabulated if received any time prior to 1 June 1941. Therefore, the completeness estimate for December was biased upward, and that for the other months biased downward.

Somewhat fewer than 6000 test records were counted as unmatched because the corresponding birth certificates had been filed after 31 July 1940. If they had all been accepted, the estimated percentage of completeness would have been increased by only 0·7%. In some States, the deadline was a relatively more important factor than for the country as a whole.

(4) Available information indicates that biases arising from undermatching and overmatching tended to overstate slightly registration completeness for the country as a whole. The former type of error was less likely to occur, since every means possible was utilized in locating a birth record to match an infant card. Despite these efforts, it was estimated that between 1000 and 3000 infant cards remained unmatched at the end of the test because of name difficulties rather than because the birth certificates had not been filed.

On the other hand, clerical errors and fortuitous agreement between test records may have resulted in many more improper matches, although rigid control over the operation and careful supervision tended to minimize these factors. Evaluation of the situation suggested that overmatching affected about 3–4 times as many records as undermatching.

Registration completeness, 1940–1948

The results of the 1940 birth-registration test formed the basis for State campaigns directed at attendants and local registrars to improve registration. However, before all of the necessary administrative actions could be taken, State and local vital statistics offices were overwhelmed by the war-time demands made upon them for copies of birth certificates. Furthermore, requirements of the armed forces and war-connected industries rapidly depleted their staffs. Thus, the information derived from the test could not be exploited as fully for promoting registration completeness as had been anticipated.

The factors which diverted efforts from organized promotional activities, at the same time, resulted in making millions of young adults more conscious of the importance of the birth record. Never before was there such a high premium placed on having a birth certificate. Citizenship had to be established to qualify for jobs in defence industry; applications for food ration books frequently had to be accompanied by the birth record of a newly born child; and birth certificates of dependant children often had to be submitted by servicemen in applying for family allowances. It is difficult to estimate how this situation affected the attendants responsible for filing records. But it seems likely that they were influenced by the demonstrated value of the birth record to their patients, neighbours and friends.

Another factor which is believed to have improved registration completeness is the vast increase in the utilization of hospital facilities for confinement. In 1940, 56% of births occurred in hospitals. By 1948, the proportion had increased to over 86%. Practically every area of the country and race group showed a marked rise in hospital confinements. In the non-white race, where registration was poorest, the percentage doubled (from 26·7 to 52·9%).

The effect on registration completeness of increased use of hospitals for delivering babies has been measured under the assumption that the 1940 percentages of registration completeness of births occurring in hospitals and institutions within each State

Table 5. *Estimated percentages of birth-registration completeness: United States*, 1935–1948

Year	Total	White	Non-white
1948	95·5	97·1	85·9
1947	95·5	97·0	85·3
1946	95·1	96·7	84·4
1945	94·5	96·3	83·3
1944	94·1	96·0	82·7
1943	93·9	95·6	82·3
1942	93·5	95·3	81·9
1941	92·8	94·5	81·6
1940	92·3	94·0	81·3
1939	91·9	93·6	81·1
1938	91·6	93·4	80·8
1937	91·3	93·1	80·4
1936	91·1	92·8	80·2
1935	90·7	92·4	79·9

and race group and the comparable figures for home deliveries remained unchanged.[1] The figures in Table 5 were obtained by applying these percentages to registered birth data classified by State, race and occurrence in or out of hospital for each of the years given. United States totals were then obtained by cumulating State figures corrected for under-registration. The percentages in the table show the steady increase in completeness suggested by this method.

The possibility that war-time factors may have altered the relationships determined in 1940 should not be overlooked. It is also extremely unlikely that they operated exactly the same way each year in all States. Nevertheless, the assumption represents the most reasonable approach to estimating registration completeness for the years in which 'in or out of hospital' statistics are available (1935–48).

The 1950 test of registration completeness

Another nation-wide test of birth-registration completeness is being conducted in conjunction with the 1950 Decennial Census of Population and Housing. State interest in carrying out active promotional campaigns to eliminate under-registration has been very high. In the years following the end of World War II, renewed efforts in this direction have been made in some areas, but the lack of information about changes in local situations has retarded these activities.

The Federal offices planning the 1950 test are the Public Health Service (National Office of Vital Statistics),[2] and the Bureau of the Census (Population Division). All State offices of vital statistics are actively participating in various phases of the project. From the standpoint of birth registration, the primary purpose of the test is the same as in 1940: to obtain measures of registration completeness in States and local areas on a comparable basis. The results will help registrars to localize problem areas for registration promotion and to conduct surveys to determine reasons for failure to register births. The test will also make available correction factors for vital statistics based on registered births and provide data for special analytical studies.

The Bureau of the Census will use the 1950 test to determine (1) variations in infant enumeration completeness by social and economic groups in the population and (2) reasons for failure to enumerate infants.

The source of records in the 1950 test is the same as in 1940. Infant cards (Fig. 3) are being filled out for all enumerated infants who were born between 1 January and 31 March 1950. This is 1 month less coverage than in 1940, but the total number of births will probably exceed the total for the 4 months, 1 December 1939 to 31 March 1940. Copies of birth records and infant death records for events occurring during the test period are being furnished by State offices of vital statistics.

Experience gained in the 1940 test is being utilized to control various sources of bias and increase the efficiency of the matching operation. Follow-up of unmatched birth records, a necessary step to obtain measures of underenumeration, will reveal

[1] I. M. Moriyama, *Estimated Completeness of Birth Registration: United States*, 1935–1944, Vital Statistics, Special Reports, vol. XXIII, no. 10, Federal Security Agency, United States Public Health Service, National Office of Vital Statistics, 30 September 1946.

[2] The Division of Vital Statistics was transferred July 1946 from the Bureau of the Census to the Public Health Service, Federal Security Agency, and renamed the National Office of Vital Statistics.

CONFIDENTIAL This inquiry is authorized by Act of Congress (46 Stat. 21; 13 U. S. C. 201–218) which requires that a report be made. The information furnished is accorded confidential treatment. The Census report cannot be used for purposes of taxation, investigation, or regulation.

BUDGET BUREAU NO. 41-4901.
APPROVAL EXPIRES Dec. 31, 1950.

FORM **P 3** U. S. DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

INFANT CARD

1950 CENSUS OF POPULATION AND HOUSING

(For every child born in January, February, or March 1950)

1. Is residence on a farm? (Copy from Population schedule item 4 for "head of household.") Yes [1] No [2]

2. NAME OF INFANT (Please print)
(Last) (First) (Initial)

3. RACE OF INFANT (Copy from schedule item 9.) White [1] Negro [2] American Indian [3] Other [4]

4. SEX OF INFANT (Copy from schedule item 10.) Male [1] Female [2]

5. Is father enumerated in this household? Yes [1] No [2]

IF "YES" in item 5, copy the answers to items 6, 7, 8, and 9, from the Population schedule. If "NO" in item 5, skip to item 10.

6. NAME OF FATHER (Please print) (Copy from schedule item 7.)
(Last) (First) (Initial)

7. AGE OF FATHER ON LAST BIRTHDAY (Copy from schedule item 11.)

8. OCCUPATION OF FATHER (Copy from schedule item 20a; if that item is blank, enter "None.")

9. INDUSTRY OF FATHER (Copy from schedule item 20b; if that item is blank, enter "None.")

LEAVE BLANK

LEAVE BLANK | A | B | C

State _____ County _____

E. D. No. _____ Sheet No. _____ Line No. _____

Enumerated by _____

Date _____

LEAVE BLANK

ASK THESE ITEMS

10. DATE OF BIRTH
_____ (Month) _____ (Day), 1950

11. POST OFFICE ADDRESS OF INFANT'S USUAL PLACE OF RESIDENCE
House Number and Street or RFD No. _____

City or Town _____ State _____

12. INFANT'S PLACE OF BIRTH (ACTUAL PLACE—NOT USUAL RESIDENCE)

LEAVE BLANK

City _____ (If outside city limits, write "RURAL.")

County _____ State _____

13. NAME OF HOSPITAL

If "NONE" above, type of attendant at birth:
Doctor [1] Midwife [2] Other (Specify) _____

14. MAIDEN NAME OF MOTHER (Please print)
(Last) (First) (Initial)

15. AGE OF MOTHER ON LAST BIRTHDAY (Copy from schedule item 11, or ask question.)

16. EDUCATION OF MOTHER (Copy from schedule items 26 and 27 or ask questions.)
a. What is the highest grade of school that she has attended? _____
b. Did she finish this grade? Yes [1] No [2]

17. ORDER OF BIRTH
Is this the 1st, 2d, etc., child the mother has ever borne? (Do not count stillbirths but count all live births, including children now deceased.) _____

U. S. GOVERNMENT PRINTING OFFICE 16—58005-1

Fig. 3.

matching errors that remained undetected in 1940. The test provides, as in 1940, for a mail survey to parents to verify and correct information on residual groups of unmatched infant cards and for a final search in State offices. Intensive field work is being planned by many States to determine the reasons for under-registration.

IV. National birth statistics

Collection of data

With the formation of the B.R.A. in 1915, there began an annual series of birth statistics, which covered the entire United States for the first time in 1933. The course followed in obtaining data from these records has remained unchanged. The geographic unit of registration has been the city, town, county or other civil subdivision which is served by a local registrar of vital statistics who is required to see that each certificate is complete and accurate. When received in the State bureau of vital statistics, the certificates are inspected further for completeness, queried if necessary, numbered, indexed and bound for permanent reference. In the State office, statistical information from the certificates is tabulated for use by the State and local health departments, other branches of the State government, and private organizations.

A copy of each birth certificate received in State offices is sent to the National Office of Vital Statistics. Annual tabulations of birth facts are prepared from these copies for the United States and, in comparable form, for each State included in the B.R.A. Until 1946, only statistical transcripts of the entries on the record were utilized to transmit the data. On 1 January 1946, after several years of experimentation by State offices, microfilm was introduced primarily to eliminate possible errors in transcription and reduce storage space. By 1949, the National Office of Vital Statistics was receiving microfilm copies of over 70% of the year's birth records.

Various methods have been used to ensure the completeness and accuracy of information on the birth record. Since 1939, physicians have received successive issues of the *Physician's Handbook on Birth and Death Registration*. This publication is designed to explain the doctor's responsibility for filing certificates and how to fill them in. A number of States, where midwives attend a relatively large proportion of the births, prepare special handbooks and pamphlets directed at this group and hold classes which include discussions of the items on the birth record.

Of considerable significance in controlling the quality of the data on birth records are the query programmes that have been carried out for years by every State. At one time, queries were concerned only with individual items (e.g. inconsistent entries, obviously incorrect data and missing information). In the past few years, this procedure has been supplemented by a more general type of inquiry. Parents are mailed a form containing information exactly as it appears on the birth record with the request that they review the entries and mail the form back with necessary corrections.

Comparability of data

Necessary prerequisites for the issuance of comparable national birth statistics have been a uniform definition of live birth and the adoption by States of practically all items recommended on successive issues of the Standard Certificate of Birth. The

definition of live birth has varied only in specificity from the one now in use: 'A child showing any evidence of life (action of heart, breathing, or movement of voluntary muscle) after complete birth should be registered as a live birth. Birth is considered complete when the child is altogether (head, trunk, and limbs) outside the body of the mother, even if the cord is uncut and the placenta still attached.'

Revisions of the Standard Certificate have been carried out periodically with the advice and co-operation of State registrars and organizations working in the fields of public health, social welfare, demography and insurance. Each revision has subjected the old items to a careful review in terms of their current and future usefulness for registration, identification, legal, medical and research purposes. New items have been added when necessary.

Copies of the Standard Certificate of Birth in effect when the B.R.A. was formed and the most recent version (1949) are shown in Fig. 4. Several of the important changes reflected by these certificates and the years in which they were first adopted follow.

(1) Increased prominence for the item on 'usual residence of mother' (1939). The large movement to utilize hospital facilities outside the mother's home area for confinement has made place-of-residence tabulations essential.

(2) Provision of separate Standard Certificates for the reporting of live births and stillbirths (1939). Previously, the general practice was to use the same certificate for both the 'born alive' and 'stillborn' with a death certificate also required in the case of stillbirth.

(3) Establishment of a 'medical and health section' (1949) as an integral part of the Standard Certificate. Items appearing in this section are confidential and are to be omitted when copies are certified for ordinary purposes. This is intended to prevent unnecessary embarrassment to the child or his parents when such facts as illegitimacy or malformations appear on the birth records.

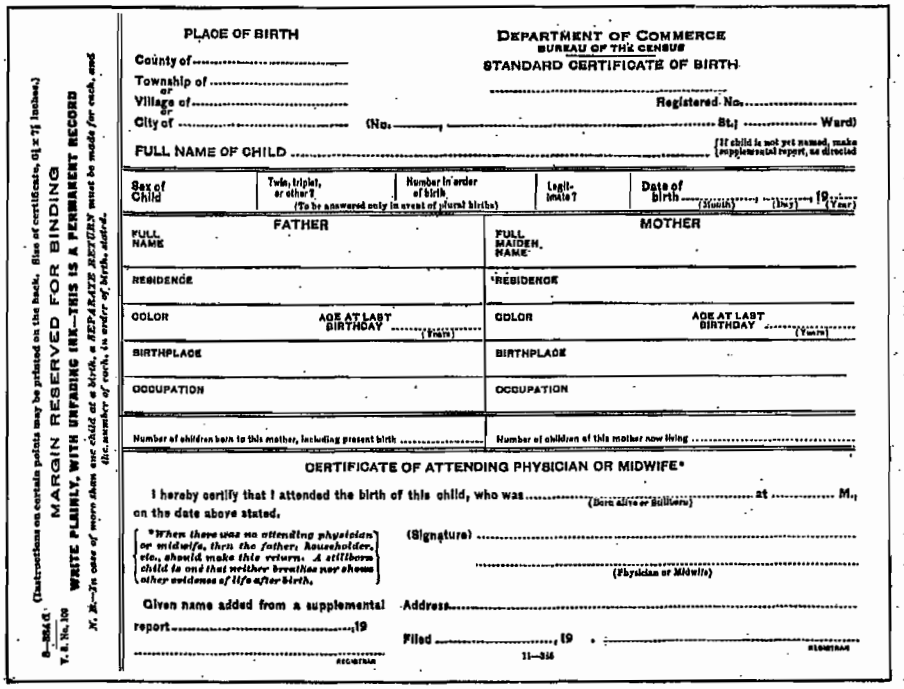
The medical section is used by many States to accommodate various items including: complications of pregnancy, operations for delivery, congenital malformations, birth injuries, and the use of a prophylactic drug in the baby's eyes. Prior to 1949, many States had already adopted these items and placed them in a similar type section.

(4) Improvement of items to ensure better reporting and dropping others which have little or no possibility of being used. An example of improvement is the change in the children 'ever born' item. It was not possible to determine from the entries on the 1915–17 certificate whether the information referred to 'ever born including stillbirths' or 'ever born alive'. The 1918 revised Standard Certificate called for a three-part item which eliminated this ambiguity.

(5) Addition of an item on birth weight and specification of period of gestation in weeks (1949). These will form the basis for studies of premature births.

Tabulation and publication of data

From the very beginning, national tabulations of birth data have been extensive, being designed to meet a variety of needs in many fields including demography, health, education and business. Tabulations prior to 1930 were concerned with



(Instructions on certain points may be printed on the back. Size of certificate, 6½ x 7½ inches.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—In case of more than one child at a birth, a SEPARATE REVIEW must be made for each, and the number of each, in order of birth, stated.

8—354.6
T. E. No. 100

PLACE OF BIRTH

County of .....

Township of .....
or
Village of .....
or
City of .....

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STANDARD CERTIFICATE OF BIRTH

Registered No. .....

(No. ....., ... St.) ..... Ward)

FULL NAME OF CHILD ..... (If child is not yet named, make supplemental report, as directed)

Sex of Child	Twin, triplet, or other? (To be answered only in event of plural births)	Number in order of birth (To be answered only in event of plural births)	Legitimate?	Date of birth (Month) (Day) 19 (Year)

FATHER	MOTHER
FULL NAME	FULL MAIDEN NAME
RESIDENCE	RESIDENCE
COLOR — AGE AT LAST BIRTHDAY ..... (Years)	COLOR — AGE AT LAST BIRTHDAY ..... (Years)
BIRTHPLACE	BIRTHPLACE
OCCUPATION	OCCUPATION
Number of children born to this mother, including present birth	Number of children of this mother now living .....

CERTIFICATE OF ATTENDING PHYSICIAN OR MIDWIFE*

I hereby certify that I attended the birth of this child, who was ..... (Born alive or Stillborn) at ..... M., on the date above stated.

**When there was no attending physician or midwife, then the father, householder, etc., should make this return. A stillborn child is one that neither breathes nor shows other evidence of life after birth.*

(Signature) .....

(Physician or Midwife)

Given name added from a supplemental report ..... 19 .....

Address .....

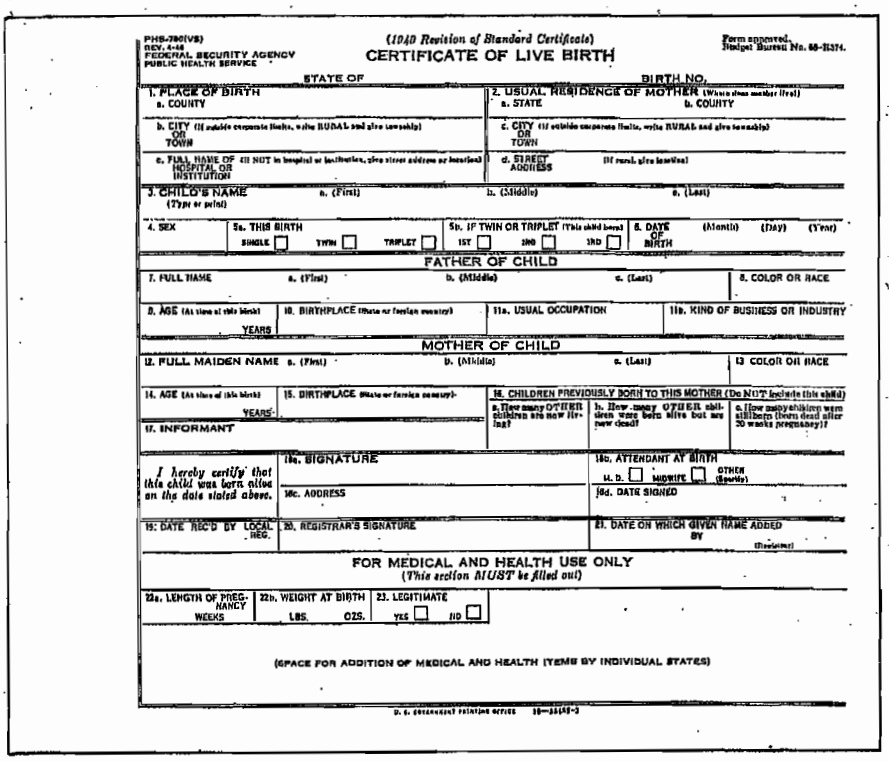
Filed ..... 19 .....

REGISTRAR

11—356

REGISTRAR

Fig. 4*a*. In Effect 1915–1917.



PHS-7801(VS)
REV. 6-48
FEDERAL SECURITY AGENCY
PUBLIC HEALTH SERVICE

(1940 Revision of Standard Certificate)

CERTIFICATE OF LIVE BIRTH

Form approved.
Budget Bureau No. 68-R374.

STATE OF ..... BIRTH NO. .....

1. PLACE OF BIRTH	2. USUAL RESIDENCE OF MOTHER (Where does mother live?)
a. COUNTY	a. STATE — b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital or institution, give street address or location)	d. STREET ADDRESS (If rural, give location)

3. CHILD'S NAME (Type or print) — a. (First) — b. (Middle) — c. (Last)

4. SEX	5a. THIS BIRTH	5b. IF TWIN OR TRIPLET (This child born)	6. DATE OF BIRTH (Month) (Day) (Year)
	SINGLE ☐ TWIN ☐ TRIPLET ☐	1ST ☐ 2ND ☐ 3RD ☐	

FATHER OF CHILD

7. FULL NAME	a. (First)	b. (Middle)	c. (Last)	8. COLOR OR RACE

9. AGE (At time of this birth) YEARS	10. BIRTHPLACE (State or foreign country)	11a. USUAL OCCUPATION	11b. KIND OF BUSINESS OR INDUSTRY

MOTHER OF CHILD

12. FULL MAIDEN NAME	a. (First)	b. (Middle)	c. (Last)	13. COLOR OR RACE

14. AGE (At time of this birth) YEARS	15. BIRTHPLACE (State or foreign country)	16. CHILDREN PREVIOUSLY BORN TO THIS MOTHER (Do NOT include this child)		
		a. How many OTHER children are now living?	b. How many OTHER children were born alive but are now dead?	c. How many children were stillborn (born dead after 20 weeks pregnancy)?

17. INFORMANT

I hereby certify that this child was born alive on the date stated above.

18a. SIGNATURE	18c. ATTENDANT AT BIRTH
18b. ADDRESS	M. D. ☐ MIDWIFE ☐ OTHER (Specify)
	18d. DATE SIGNED

19. DATE REC'D BY LOCAL REG.	20. REGISTRAR'S SIGNATURE	21. DATE ON WHICH GIVEN NAME ADDED BY (Registrar)

FOR MEDICAL AND HEALTH USE ONLY
(This section MUST be filled out)

22a. LENGTH OF PREGNANCY WEEKS	22b. WEIGHT AT BIRTH LBS. OZS.	23. LEGITIMATE YES ☐ NO ☐

(SPACE FOR ADDITION OF MEDICAL AND HEALTH ITEMS BY INDIVIDUAL STATES)

U. S. GOVERNMENT PRINTING OFFICE 16—35549-3

Fig. 4*b*. In Effect 1949–

the following items: race, age of parents, nativity and country of birth of white parents, legitimacy status, birth order (excluding stillbirths) and number of children 'living'. Occupation of father was tabulated every year between 1923 and 1929, and crossed by several of their items.

After 1930, occupational coding was discontinued because of the unavailability of comparable data for the population as a whole.[1] Country of parent's birth was dropped in 1937, since the foreign-born became less important components of the population in the reproductive age span. One of the most important changes during the 1930's was the shift in emphasis from place of occurrence to place of residence in tabulating data. The first State tables prepared by place of residence were available for 1935 events. The 1939 tabulations carried this concept much further, and most of the data being used to-day for analytical purposes or health programme needs are on a residence basis. Typical cross-tabulations prepared in recent years are indicated in Table 6.

Table 6. *Summary of* 1948 *natality tabulations*

I. *Each State by place of occurrence and by place of residence.*
- (X) Each urban place of 10,000+. Totals by county for urban places under 10,000 and rural areas.
- (X) Population groups: urban places of 100,000+, 25,000–100,000, 10,000–25,000, 2500–10,000, rural.
- (X) Race: white, non-white.
- (*a*) Person in attendance: physician in hospital, physician out of hospital, midwife, other and not stated.
- (*b*) Legitimacy status:* Illegitimate, legitimate and not stated.

II. *Each State by place of occurrence and by place of residence.*
- (X) Age of mother: Under 15, single units of age (15–49), 50+, not stated.
- (X) Nativity of white mother.
- (X) Race: white, negro, other.
- (X) Sex of child.
- (*a*) Population groups:† Urban places of 100,000+, 25,000–100,000, 10,000–25,000, 2500–10,000, rural.
- (*b*) Age of father: 10–54, by 5-year age groups, 55+ and not stated.
- (*c*) Race: Indian, Chinese, Japanese, other.
- (*d*) Nativity of father.
- (*e*) Legitimacy status:* Legitimate, illegitimate, not stated.
- (*f*) Number of children born alive (mother):‡ 1, 2, 3, ..., 17+, not stated.
- (*g*) Month of birth.

Note. Separate tabulations of plural births by number born alive, race, number and sex of mates and by age of mother are prepared annually.

Explanation of notations. Subjects noted by symbol 'X' are cross-tabulated with each other and with all lettered subjects. The lettered subjects are not cross-tabulated with each other.

* Legitimacy status not reported by sixteen States in 1948.
† By place of residence only.
‡ Birth order data available for forty-seven States and the District of Columbia.

Much of the tabulated data have appeared in the annual volume *Vital Statistics of the United States*.[2] A series of reports entitled *Vital Statistics—Special Reports*,

[1] This point is now being reconsidered. Comparability between occupational information recorded on the birth record and the data obtained in the Census will be reviewed on the basis of common entries on the infant card and birth record used in the 1950 study of registration and infant enumeration completeness. Furthermore, the present series of *Current Population Surveys* (Bureau of the Census) provide the opportunity to obtain occupational data for the population in intercensal years.

[2] Prior to 1937, birth data were published in the volumes entitled *Birth, Stillbirth, and Infant Mortality Statistics*.

containing selected tables and analyses, was initiated in 1934. There are now three distinct sets of reports which come under this title: (*a*) 'National Summaries'—an annual series presenting national data on important aspects of births, deaths, marriages and divorces, organized in the form of a special report for each subject; (*b*) 'State Summaries'—an annual series consisting of individual and comparable reports on each State and territory and a United States summary; (*c*) 'Selected Studies'—a series of special articles in the field of vital statistics and vital registration published irregularly.

To provide a basis for judging current changes in the birth rate, monthly telegraphic reports on the number of birth records being filed are obtained from the State offices. These reports are published in the *Monthly Vital Statistics Bulletin* shortly after they are received.

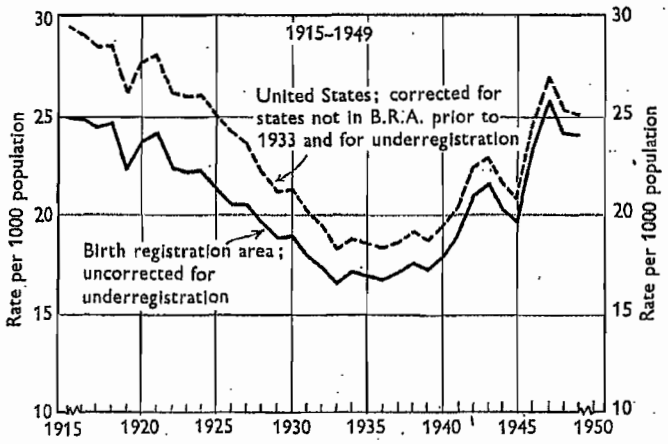


Fig. 5. Crude birth rate: birth registration area and United States.

While the data tabulated for the expanding B.R.A. have been adequate for many purposes, close study of changes in the birth rate requires that adjustments be made for States not included in the B.R.A. prior to 1933 and for underregistration. Fig. 5 indicates, for example, that the decline in the crude birth rate from the post World War I level to the low point in 1933 was actually somewhat steeper in the adjusted series[1] than would be judged from registered birth data. It will also be observed that the 1947 rate based on registered events was the high point for the B.R.A. However, the corrected data suggest that the rate in the post World War II period did not quite reach the 1920–1 level.

[1] Correction factors are from the following sources: (*a*) for the years 1915–34, which contain adjustments for States not in the B.R.A. and for under-registration, from a paper by P. K. Whelpton to be published shortly in *Vital Statistics—Special Reports*, National Office of Vital Statistics; (*b*) for the years 1935–48, from Table 5. Methods used in preparing the two sets of factors make them consistent with each other. The 1949 data are preliminary estimates.

Present statistical requirements

The ending of registration incompleteness as a practical statistical matter is still one of the most important objectives to-day. In addition, it is necessary to continue subjecting the basic data derived from birth records to tests of reliability and uniformity.

Opportunities for analysing the wealth of data that have been tabulated are present, but the need for new data is acute. The increased complexity of questions in the analysis of fertility has made it essential to obtain information not now available (e.g. duration of marriage, interval between births, socio-economic status). Special surveys which go beyond the confines of the birth record will undoubtedly have a significant part in developing such statistics.

Correlation of facts on the birth record with those on other records is a prerequisite for many new advances in the health and welfare fields. An outstanding example is the gain to be made in relating information on matched birth and death records in studying prematurity. This is not only true on a national level, but even more so on a State and local level. To meet present-day statistical requirements, it will undoubtedly be necessary to go beyond the confines of the birth record.

TAB M

DECLARATION OF VALERIA S. DESHIELDS

The undersigned, Valeria S. DeShields, having been duly sworn, certifies under penalty of perjury under the laws of the United States of America that the following is true and correct:

1. My name is Valeria S. DeShields. I am over eighteen years of age and competent to testify. I have personal knowledge of the matters and facts set forth in this Affidavit.
2. I am the family representative for my husband, Alphonso DeShields.
3. For purposes of this affidavit, "to the best of my knowledge" includes statements made by my husband, Alphonso DeShields, and other family members over the course of time.
4. To the best of my knowledge, Alphonso DeShields is a United States Citizen.
5. To the best of my knowledge, Alphonso DeShields is 91 years old, having been born on September 8, 1914.
6. To the best of my knowledge, Alphonso DeShields was born in Spartanburg, South Carolina, United States of America.
7. To the best of my knowledge, Alphonso DeShields was not born in a hospital, but was born in his parents' home.
8. To the best of my knowledge, for the last 91 years, Alphonso DeShields has lived in South Carolina and Washington, D.C.
9. Alphonso DeShields currently resides and has resided for the last 5 years at 5425 Western Avenue NW, Washington, D.C., 20015.

10. To the best of my knowledge, Alphonso DeShields currently suffers from the following health conditions: severe peripheral vascular disease, hypertensive cardiovascular disease, cardiomegally (enlarged heart), prostate cancer, left hip socket arthroplasty, acute small bowel obstruction and tubovillous adenoma.

11. To the best of my knowledge and to treat the aforementioned health conditions, it is medically necessary for Alphonso DeShields to not only receive skilled nursing services in a residential, skilled nursing facility, but also to receive rehabilitation therapy and recreational therapy. In addition, Alphonso DeShields' routine medications include, but are not limited to, acetaminophen, aspirin, bisacodyl, guaifenesin, tramadol HCL, diovan, furosemide, megestrol acetate, nitrek, norvasc, ranitidine, and zoladex.

12. To the best of my knowledge, Alphonso DeShields currently meets each of the eligibility requirements necessary to remain enrolled in Washington, D.C.'s Medicaid program (the "Program"). Specifically:

    a. He is a United States citizen.

    b. His income level is at or below the level of the Program's eligibility requirements.

    c. His resource levels are at or below the Program's eligibility requirements.

13. To the best of my knowledge, the date of Alphonso DeShields' initial application to enroll in the Program was 9/19/2001, with a retroactive effective date of 9/4/2001.
14. To the best of my knowledge, Alphonso DeShields has been enrolled in the Program since 9/4/2001 and, as of the date signed below, continues to be so enrolled.
15. To the best of my knowledge, as a current Medicaid beneficiary, the health care providers that provide the skilled nursing and other services necessary to treat Alphonso DeShields' aforementioned health conditions, including, but not limited to, The Lisner-Louise-Dickson-Hurt Home, are reimbursed by the Program.
16. To the best of my knowledge and because of Alphonso DeShields' income and resource levels, Alphonso DeShields is unable to personally reimburse The Lisner-Louise-Dickson-Hurt Home and the other healthcare providers that provide skilled nursing services and other healthcare services to Alphonso DeShields, respectively.
17. Alphonso DeShields will lose access to skilled nursing services and treatment for severe peripheral vascular disease, hypertensive cardiovascular disease, cardiomegally (enlarged heart), prostate cancer, left hip socket arthroplasty, acute small bowel obstruction and tubovillous adenoma if the providers of those services are not reimbursed.

18. If Alphonso DeShields does not receive skilled nursing services and/or treatment for severe peripheral vascular disease, hypertensive cardiovascular disease, cardiomegally (enlarged heart), prostate cancer, left hip socket arthroplasty, acute small bowel obstruction and tubovillous adenoma, his health status would quickly, irreparably and irreversibly decline.

19. With respect to each of the following documents and to the best of my knowledge, Alphonso DeShields possesses neither an original of such a document nor a copy of such a document certified by the original issuing agency, whether valid or expired, if applicable. Furthermore and to the best of my knowledge, Alphonso DeShields cannot obtain either an original document nor a copy of such a document certified by the original issuing agency within forty-five (45) days from the date of request, or within any reasonable period of time:

    a. Unites States Passport.

    b. Form N-550 or N-570 (Certificate of Naturalization).

    c. Form N-560 or N-561 (Certificate of United States Citizenship).

    d. State-issued driver's license.

    e. State-issued identification document other than a State-issued driver's license.

    f. Certificate of birth in any one of the fifty (50) States, the District of Columbia, American Samoa, Swain's Island, Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, or Guam.

g. Form FS-545 (Certification of Birth Abroad).

h. Form DS-1350 (Certification of Report of Birth).

i. Form I-197 (United States Citizen Identification Card).

j. Form FS-240 (Consular Report of Birth Abroad of a Citizen of the United States).

k. American Indian Card (I-872).

l. Northern Mariana Card (I-873).

m. A final adoption decree.

n. Evidence of civil service employment by the U.S. government before June 1, 1976.

o. Official Military record of service.

p. Extract of a hospital record, on hospital letterhead, established at the time of his birth, that indicates the place of his birth.

q. Life or health or other insurance record showing the place of his birth and that was created on or before 9/19/1996.

r. Federal or State census record showing either his U.S. citizenship or his place of birth.

s. Seneca Indian tribal census record showing his place of birth and that was created on or before 9/19/1996.

t. Bureau of Indian Affairs tribal census record of the Navaho Indians showing his place of birth and that was created on or before 9/19/1996.

u. U.S. State Vital Statistics official notification of birth registration showing his place of birth and that was created on or before 9/19/1996.

v. An amended U.S. public birth record that was amended after he turned 5 years of age, that shows his place of birth and that was created on or before 9/19/1996.

w. Statement signed by the physician or midwife who was in attendance at the time of his birth, that shows his place of birth and that was created on or before 9/19/1996.

x. Institutional admission papers from a nursing home, skilled nursing care facility or other institution that show his place of birth and that was created on or before 9/19/1996.

y. A record from a clinic, doctor or hospital that is not an immunization record but that shows his place of birth and that was created on or before 9/19/1996.

20. With respect to each of the following documents and to the best of my knowledge, Alphonso DeShields possesses neither an original of such a document nor a copy of such a document certified by the original issuing agency, whether valid or expired, if applicable. Furthermore and to the best of my knowledge, Alphonso DeShields cannot obtain either an original document nor a copy of such a document certified by the original issuing agency within forty-five (45) days from the date of request, or within any reasonable period of time:

a. Certificate of Degree of Indian Blood, or other U.S. American Indian / Alaska Native tribal document.

b. School identification card with his photograph.

c. U.S. military card or draft record.

d. Identification card issued by a Federal, State, or local government that includes the same information included on State driver's licenses.

e. Military dependent's identification card.

f. Native American tribal document

g. U.S. Coast Guard Merchant Mariner card.

21. To the best of my knowledge, Alphonso DeShields does not know two (2) individuals that have personal knowledge of his September 4, 1914 birth in Spartanburg, South Carolina, United States of America.

22. To the best of my knowledge, when Alphonso DeShields previously attempted to procure a certified copy of his birth certificate from the Census Bureau in Suitland, Maryland, the census bureau informed him that the government office in Spartanburg, South Carolina had been destroyed by fire and all of its records were lost and/or destroyed, including, but not limited to, any birth certificate of Alphonso DeShields' birth that it may have previously possessed. This was later confirmed by the United States Social Security office when Alphonso DeShields attempted to obtain Medicare.

23. To the best of my knowledge, Alphonso DeShields previously applied for, received and subsequently lost a United States passport. Alphonso

DeShields was able to procure that passport by presenting old pictures from his childhood, which he has also subsequently lost.

24. It is my understanding that, because Alphonso DeShields does not possess and/or cannot obtain any of the documents as stated above, and further because he does not know two (2) individuals that have personal knowledge of his September 4, 1914 birth, and further as a result of the Defendants' impending actions, Alphonso DeShields' Program eligibility will be terminated.

25. As a result of the Defendants' impending actions, Alphonso DeShields' health status will quickly, irreparably and irreversibly decline.

Valeria S. DeShields

Valeria S. DeShields
5425 Western Ave NW #106-1
Washington DC 20015

TAB N

DECLARATION OF MARGARET MATTHEWS.

The undersigned, Margaret Matthews, having been duly sworn, certifies under penalty of perjury under the laws of the United States of America that the following is true and correct:

1. My name is Margaret Matthews.
2. I am a United States Citizen.
3. I am 84 years old, having been born on January 25, 1922.
4. I was born in Alberta, Virginia, United States of America.
5. I was not born in a hospital; I was born in my parents' home.
6. For the last 84 years, I have lived in Virginia and Washington, D.C.
7. I currently reside and have resided for the last 2 years at 5425 Western Avenue NW, Washington, D.C., 20015
8. I currently suffer from the following health conditions: S/P periprosthetic FX open reduction & internal fixation of right femur, hypertensive cardiovascular disease with compensated congestive heart failure, coronary artery disease with sudden chest pains, brittle diabetes with insulin dependency, hypertension, gastroesophegal reflux disease, similar to acid, multiple arthritis, effects from a cerebral vascular accident, dementia and renal insufficiency.
9. To treat the aforementioned health conditions, it is medically necessary for me to not only receive skilled nursing services in a residential, skilled nursing facility, but also to receive acetaminophen, glutose, nitroquick,

prochlorperazine, clonidine HCL, colchicines, coreg, digitek, diltiazem HCL, gabapentin, insulin, isosorbide dinitrate, lipitor, mirtazapine, prednisone, prilosec, voltaren ophthalmic, warfarin, and xalatan.

10. I currently meet each of the eligibility requirements necessary to remain enrolled in Washington D.C.'s Medicaid program (the "Program"). Specifically:

    a. I am a United States citizen.

    b. My income level is at or below the level of the Program's eligibility requirements.

    c. My resource levels are at or below the level of the Program's eligibility requirements.

11. The date of my initial application to enroll in the Program was October 24, 2003, with a retroactive effective date of October 10, 2003.

12. I have been enrolled in the Program since October 10, 2003 and as of the date signed below, continue to be so enrolled.

13. As a current Medicaid beneficiary, the health care providers that provide the skilled nursing and other services necessary to treat my aforementioned health conditions, including, but not limited to, The Lisner-Louise-Dickson-Hurt Home, are reimbursed by the Program.

14. Because of my income and resource levels, I am unable to personally reimburse The Lisner-Louise-Dickson-Hurt Home and the other healthcare

providers that provide skilled nursing services and other healthcare services to me, respectively.

15. I will lose access to skilled nursing services, restorative therapy, and recreational therapy if the providers of those services are not reimbursed, as well as access to all necessary treatments and medications.

16. If I do not receive skilled nursing services and/or treatment for S/P periprosthetic FX open reduction & internal fixation of right femur, hypertensive cardiovascular disease with compensated congestive heart failure, coronary artery disease with sudden chest pains, brittle diabetes with insulin dependency, hypertension, gastroesophegal reflux disease, similar to acid, multiple arthritis, effects from a cerebral vascular accident, dementia and renal insufficiency, my health status would quickly, irreparably and irreversibly decline.

17. With respect to each of the following documents, I possess neither an original of such a document nor a copy of such a document certified by the original issuing agency, whether valid or expired, if applicable. Furthermore, I cannot obtain either an original document nor a copy of such a document certified by the original issuing agency within forty-five (45) days from my date of request, or within any reasonable period of time:

    a. Unites States Passport.

    b. Form N-550 or N-570 (Certificate of Naturalization).

    c. Form N-560 or N-561 (Certificate of United States Citizenship).

d. State-issued driver's license.

e. State-issued identification document other than a State-issued driver's license.

f. Certificate of birth in any one of the fifty (50) States, the District of Columbia, American Samoa, Swain's Island, Puerto Rico, the U.S. Virgin Islands, the Northern Mariana Islands, or Guam.

g. Form FS-545 (Certification of Birth Abroad).

h. Form DS-1350 (Certification of Report of Birth).

i. Form I-197 (United States Citizen Identification Card).

j. Form FS-240 (Consular Report of Birth Abroad of a Citizen of the United States).

k. American Indian Card (I-872).

l. Northern Mariana Card (I-873).

m. A final adoption decree.

n. Evidence of civil service employment by the U.S. government before June 1, 1976.

o. Official Military record of service.

p. Extract of a hospital record, on hospital letterhead, established at the time of my birth, that was created on or before October 24, 1998, and that indicates the place of my birth.

q. Life or health or other insurance record showing the place of my birth and that was created on or before October 24, 1998.

r. Federal or State census record showing either my U.S. citizenship or my place of birth.

s. Seneca Indian tribal census record showing my place of birth and that was created on or before October 24, 1998.

t. Bureau of Indian Affairs tribal census record of the Navaho Indians showing my place of birth and that was created on or before October 24, 1998.

u. U.S. State Vital Statistics official notification of birth registration showing my place of birth and that was created on or before October 24, 1998.

v. An amended U.S. public birth record that was amended after 1927 (5 years of age), showing my place of birth and that was created on or before October 24, 1998.

w. Statement signed by the physician or midwife who was in attendance at the time of my birth, that shows my place of birth and that was created on or before October 24, 1998.

x. Institutional admission papers from a nursing home, skilled nursing care facility or other institution that show my place of birth and that was created on or before October 24, 1998.

y. A record from a clinic, doctor or hospital that is not an immunization record but that shows my place of birth and that was created on or before October 24, 1998.

18. With respect to each of the following documents, I possess neither an original of such a document nor a copy of such a document certified by the original issuing agency, whether valid or expired, if applicable:

    a. Certificate of Degree of Indian Blood, or other U.S. American Indian / Alaska Native tribal document.

    b. School identification card with my photograph.

    c. U.S. military card or draft record.

    d. Identification card issued by a Federal, State, or local government that includes the same information included on State driver's licenses.

    e. Military dependent's identification card.

    f. Native American tribal document

    g. U.S. Coast Guard Merchant Mariner card.

19. I do not know two (2) individuals that have personal knowledge of my January 25, 1922 birth in or around Alberta, Virginia, United States of America.

20. Because I do not possess and/or cannot obtain any of the documents as stated above, and further because I do not know two (2) individuals that have personal knowledge of my January 25, 1922 birth in or around Alberta, VA, United States of America, my eligibility for Medicaid will be terminated.

21. Because I do not possess and/or cannot obtain any of the documents as stated above, and further because I do not know two (2) individuals that have personal knowledge of my January 25, 1922 birth in or around Alberta, VA,

United States of America, my health status will quickly, irreparably and irreversibly decline.

Margaret Matthews
5425 Western Ave NW #104-2
Washington DC 20015

TAB O

DECLARATION OF GEORGE A. JONES

The undersigned, George A. Jones, having been duly sworn, certifies under penalty of perjury under the laws of the United States of America that the following is true and correct:

1. My name is George A. Jones. I am over eighteen years of age and competent to testify. I have personal knowledge of the matters and facts set forth in this Declaration.
2. I am the Executive Director of Bread for the City.
3. In my position, I am responsible for the oversight of the administrative and operational activities of Bread for the City, including, but not limited to, financial management and program development, including, but not limited to, as related to the medical clinic and the social and legal services that Bread for the City provides, as well as for fundraising and public relations activities.
4. Bread for the City ("Bread"), founded in 1974, is a District of Columbia non-profit corporation organized and operated as a charitable organization.
5. Bread is located in both Northwest D.C. and Southeast D.C., specifically at 1525 and 1537 Seventh Street, NW, Washington D.C., 20001 and 1640 Good Hope Road, SE, Washington D.C., 20020, which are each primary places of business for Bread.
6. Bread's mission statement is "to provide vulnerable residents of Washington, D.C., with comprehensive services, including food, clothing, medical care, and

legal and social services, in an atmosphere of dignity and respect. We recognize that all people share a common humanity, and that all are responsible to themselves and to society as a whole. Therefore, we promote the mutual collaboration of clients, volunteers, donors, staff, and other community partners to alleviate the suffering caused by poverty and to rectify the conditions that perpetuate it."

7. As a community medical clinic, Bread provides professional medical services and other medical services on an outpatient basis – free of charge – to residents of the District of Columbia. For rendering certain services to some of its patients, the District of Columbia compensates Bread through the Medicaid program.
8. Through the efforts of over 700 volunteers, including physicians and other social service providers, and the contributions of thousands of community members, Bread's staff serves over 10,000 people each month.
9. In 2005, Bread provided 2,000 uninsured women, children and men with 6,244 free medical visits.
10. Bread's patients suffer from a variety of physical and mental health conditions, including, but not limited to, common and chronic illnesses such as hypertension and diabetes.
11. To have such health conditions properly treated, it is medically necessary for Bread's patients to receive certain professional and other medical services that Bread provides, including, but not limited to, adult general medicine,

pediatrics, OB/GYN care, examinations, medications, lab tests, and referrals to specialty medical providers that provide health care services that Bread does not, such as mammograms, psychiatric, psychological and other specialty services.

12. Although Bread provides its services free of charge to patients, Bread's patients enrolled in D.C. Medicaid depend on their Medicaid benefits to afford them access to health care services that Bread is unable to provide, such as mammograms, psychiatric, psychological and other specialty services.

13. To provide medically necessary services to its patients, Bread employs one full time physician, Randi Abramson, M.D., who is Bread's Medical Clinic Director, and two other full time health care practitioners. Bread's medical staff also includes over 50 volunteer physicians, nurses, nurse practitioners, residents, students and others.

14. Dr. Abramson, who has been employed by Bread for over fifteen years, and each of Bread's employed and volunteer health care practitioners provide medical services directly to Bread's patients on a daily basis.

15. Dr. Abramson and Bread's other health care practitioners have established close relationships with their patients, including but not limited to physician-patient and practitioner-physician relationships.

16. For the vast majority of Bread's patients, Dr. Abramson and Bread's other health care practitioners are the patients' primary care practitioners and/or only medical service providers.

17. Many of Bread's patients are hindered from pursuing and protecting their own legal interests, whether as a result of physical and/or mental incapacity; lack of information or education; transience; indigence; and/or other social obstacles.

18. In addition to serving as a community medical clinic and as part of the satisfaction of its mission, Bread also provides a wide range of legal and social services to vulnerable D.C. residents, including, but not limited to, counseling, referral and case management services. In so doing, Bread's staff members specifically help D.C. residents apply for public benefits, including but not limited to, D.C. Medicaid.

19. In 2005, Bread assisted D.C. residents complete 912 public benefits applications.

20. In assisting D.C. residents complete public benefits applications, Bread staff members have, in the past, assisted some D.C. residents locate and/or attempt to locate identification documents, including, but not limited to, birth certificates, identification cards, school records, veterans' records, prison records and medical records.

21. Many Bread patients depend on Bread to assist them resolve issues of eligibility and enrollment requirements for D.C. Medicaid and other public benefit programs.

22. Many of Bread's patients that are homeless, unemployed, indigent, mentally impaired and/or otherwise facing social obstacles will encounter great

difficulty in producing or locating any of the documentation contemplated by the guidance issued by the Centers for Medicare and Medicaid Services on June 9, 2006 (the "CMS Guidance"), or will be utterly incapable of doing so.

23. Because many of Bread's patients will be incapable of producing and/or obtaining any of the documentation contemplated by the CMS Guidance, and thus will be incapable of enrolling or remaining enrolled in D.C. Medicaid on or after July 1, 2006, Bread will be unable to fulfill its mission of providing legal and social services to vulnerable D.C. residents, in that Bread will be unable to assist the resolution of its patients' D.C. Medicaid enrollment and reenrollment issues, despite the patients' eligibility to enroll or remain enrolled as United States citizens.

24. One hundred percent (100%) of the patients to which Bread provides medical and other services are indigent.

25. Approximately ten percent (10%) of the patients to which Bread provides medical and other services are enrolled in D.C. Medicaid.

26. Additional patients to which Bread provides medical and other services are eligible to enroll in D.C. Medicaid, but are not yet enrolled in D.C. Medicaid.

27. Of the medical services that Bread is compensated for providing to patients, approximately fifteen percent (15%) of such compensation is paid by D.C. Medicaid.

28. If Bread's patients that are enrolled in D.C. Medicaid were to lose their eligibility to participate in D.C. Medicaid, D.C. Medicaid would, as of the date

that such enrollees lose such eligibility, no longer reimburse Bread (or for that matter any other health care provider) for the professional and other medical services that Bread (and the other providers) provide to such patients.

29. Because of the income and resource levels of the Medicaid patients and Medicaid-eligible patients to which Bread provides medical and other services, such patients are unable to personally reimburse Bread for the services that Bread provides, or reimburse other health care providers for the services that they provide.

30. If D.C. Medicaid would no longer reimburse Bread for the professional and other medical services that it provides to D.C. Medicaid eligible patients, Bread would continue to strive to provide medical and other services, free of charge, to D.C. Medicaid enrollees. However, other health care providers, including, but not limited to, specialty health care providers, would no longer provide such services to such patients.

31. If Bread were to suffer financial loss as a result of its patients losing D.C. Medicaid eligibility, Bread would be required to reduce the amount of medical and other services that it renders to D.C. Medicaid enrollees and/or reduce the amount of medical and other services that it renders to all D.C. residents.

32. If Bread were to suffer financial loss as a result of its patients losing D.C. Medicaid eligibility, the quality of the medical and other services that Bread renders to D.C. Medicaid enrollees and other D.C. residents would be

negatively impacted, including, but not limited to, the negative impact on the provision of holistic and preventative primary care services that a lack of access to specialty services causes.

33. If health care providers other than Bread, including, but not limited to, specialty health care providers, would no longer provide medical services that Bread is unable to provide to its patients, Bread would be unable to successfully refer its patients to other providers for the medically necessary care that they need, and thus would be unable to assure that its patients receive appropriate and medically necessary care.

34. If Bread were to suffer financial loss as a result of its patients losing D.C. Medicaid eligibility, Bread's ability to fulfill its mission would be frustrated.

35. If Bread were required to reduce the amount of medical and other services that it renders to D.C. Medicaid enrollees and other D.C. residents, Bread's ability to fulfill its mission would be frustrated.

36. If the amount or quality of any of the services that Bread renders to D.C. Medicaid enrollees and other D.C. residents is reduced as a result of having to expend greater amounts of time, effort and expense in locating identification documents for Bread's patients, Bread's ability to fulfill its mission would be frustrated.

37. If the quality of the medical and other services that Bread renders to D.C. Medicaid enrollees and other D.C. residents would be negatively impacted, Bread's ability to fulfill its mission would be frustrated.

38. If Bread is unable to assure that its patients receive medically necessary care, Bread's ability to fulfill its mission would be frustrated.

6/28/06

Date

George A. Jones
Executive Director
Bread for the City