THE
CATHOLIC HEALTH
ASSOCIATION
OF THE UNITED STATES

August 9, 2004

Mr. Jim Bossenmeyer
Centers for Medicare and Medicaid Services
Center for Medicare Management
Hospital and Ambulatory Group
Department of Health and Human Services
Mail Stop C5-01-14
7500 Security Boulevard
Baltimore, MD 21244-1850

RE:Proposed Implementation Approach: Federal Funding of Emergency Health Services Furnished to Undocumented Aliens: Federal Fiscal Years 2005 through 2008.

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Dear Mr. Bossenmeyer:

The Catholic Health Association of the United States (CHA) is pleased to submit the following comments on the Proposed Implementation Approach: Federal Funding of Emergency Health Services Furnished to Undocumented Aliens: Federal Fiscal Years 2005 through 2008.

The policy paper puts forward the approach proposed by the Centers for Medicare and Medicaid Services (CMS) to implement section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, PL 108-173, (MMA).

Section 1011 provides $250 million per year for fiscal years 2005-2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens.

Documentation of Citizenship Status

We are very concerned about the implications of putting hospitals in the role of having to verify an individual's citizenship status for purposes of qualifying for payment under this provision and we urge CMS to reconsider this portion of the proposed implementation approach. We are concerned that such a requirement will deter undocumented aliens and others who are concerned about their immigration status from seeking timely and appropriate medical care. The consequences of this disincentive are obvious; these individuals will not seek treatment unless their condition deteriorates to the point where an individual is left with absolutely no choice but to seek medical care. Such an approach undoubtedly threatens his or her long-term health status. In addition, the cost of providing emergency services to individuals who delay seeking help will only increase, as providers will be faced with emergency situations of greater severity.

Additionally, Catholic hospitals are concerned about the implications if, despite their best efforts to accurately determine and document an individual's immigration status, subsequent audits find that, in fact, the individual's immigration status did not meet the eligibility standards of section 1011.

The sheer administrative burden of having to individually verify the immigration status of every individual would be overwhelming and costly. In fact, with regard to the latter, we wonder if the cost of such a detailed process would quickly overwhelm any related reimbursement.

As a consequence of these concerns, Catholic hospitals are strongly opposed to the immigration determination process that has been proposed.

As an alternative, we urge CMS to fully explore the feasibility of using the lack of a social security number as a proxy for an undocumented alien. As reported by the General Accountability Office (formerly the General Accounting Office) on May 21, 2004, this approach was used by most of the hospitals that responded to its survey. And, although the response rate was relatively low (about 39 percent from a sample of 503 hospitals), we feel that, given hospitals' understandable and natural reluctance to frighten away those who would otherwise seek help, this is a solid response rate and offers a reasonable alternative. We also urge CMS to ensure that any patient information ultimately collected under this provision can be used solely for health care-related purposes.

Claims-based Payment System

We are also concerned about the administrative burdens imposed by the claims-based payment methodology that has been proposed. The related costs of such an approach are daunting.

Instead, we would urge the use of alternative methods for establishing hospitals' allowable costs. As others have pointed out, there are at least two options that seem worthy of consideration. One is that allowed under the State Legislation Impact Assistance Grant program and the other is part of the Medicaid disproportionate share hospital program.

The use of workable cost-estimating methodologies, such as statistical sampling, appears to be far less burdensome for patients and providers than that in the proposal. Another option is to assume that the extent of utilization of emergency medical care services by undocumented aliens not enrolled in Medicaid is the same as for those enrolled is correlated. Thus, the use of such Medicaid data as a proxy would be reasonably accurate in determining a provider's eligible costs. Either of these approaches would be far less burdensome than the proposed claims-based payment system.

Unobligated State Allotments

The proposal would provide that any ". . . unobligated state funds still remaining after the annual reconciliation process . . . will be returned to the U.S. Treasury." While we appreciate the terms of the legislation, such language does not require that unexpended funds for any given year be returned to the U.S. Treasury. While the law provides that "funds appropriated under this section shall remain available until expended," the law does not require annual unexpended funds to be returned to the Treasury.

CHA urges CMS to revise this policy to provide that any annual unexpended state funds would remain in the respective state's section 1011 fund until fully expended. This approach would ensure that all of the funds appropriated under the section 1011 authority would be expended for the section's intended purpose, as enacted by Congress.

Submission of Payment Request

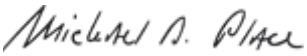
The proposal would require that a claim be filed within three months of the end of the federal fiscal quarter in which the services were rendered. CHA believes that 90 days is an insufficient time period for the submission of such claims, given that the provider must first exhaust efforts to "seek reimbursement from all available funding sources . . . [including self-pay] before requesting reimbursement under section 1011."

Given the inherent time required to fully comply with the above pre-claim submission conditions, CHA strongly urges CMS to allow 120 days for such claims submissions. This is especially relevant for providers, like Catholic hospitals, which provide emergency services to a disproportionate number of undocumented aliens.

Of course, this issue would be moot if CMS adopted a cost-estimating methodology as proposed above.

In closing, thank you for your attention to the above comments. We look forward to working with CMS in the implementation of this important provision of law.

Sincerely,



Rev. Michael D. Place, STD
President and Chief Executive Officer