

**Proposed Implementation Approach:
Federal Funding of Emergency Health Services Furnished to
Undocumented Aliens
Federal Fiscal Years 2005 Through 2008**

SUMMARY

BACKGROUND: On July 27, the Centers for Medicare and Medicaid Services (CMS) posted a policy paper that would implement Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). The provision provides \$250 million per year during FFY 2005-2008 for payments to eligible hospitals, physicians and ambulance companies for emergency health services provided to undocumented aliens and other specific aliens as required under the 1986 Emergency Medical Treatment and Labor Act (EMTALA).

Because the section did not delegate legislative rulemaking authority to the Secretary, CMS is not issuing a notice of proposed rule making or a final rule. According to CMS, the July 27 notice is the first of several steps, which will involve refinement of the implementation strategy as well as the establishment/modification of several information collection instruments.

As the law requires the Secretary to establish a process under which eligible providers may request payments under this section no later than September 1, 2004, CMS intends to use the emergency Paperwork Reduction Act of 1995 (PRA) notice and clearance process to ensure that the procedural requirements and associated policies are approved by the Office of Management and Budget (OMB) prior to that date.

INTRODUCTION: As noted above, Section 1011 provides \$250 million per year for FFY 2005-2008 in payments to eligible hospitals, physicians and ambulance companies for emergency health services provided to undocumented aliens as required by EMTALA. Two-thirds of the funds (\$167 million per year) will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third (\$85 million) will be divided among the six states with the largest number of undocumented aliens.

Payments will be made directly to hospitals, physicians and ambulance providers for some or all of the cost of providing emergency services under EMTALA. Eligible providers include critical access hospitals and may include an Indian Health Service Facility. Payments will only be made to the extent that care was not otherwise reimbursed (through insurance or otherwise).

1. Determination of State Allocation. The statute requires that two-thirds of the total yearly appropriation is proportionally divided among all 50 states and the District of Columbia (DC). The source of the information would be from the Department of Homeland Security (DHS) Office of Immigration Statistics.

The other one-third of the total yearly appropriation must be proportionally divided among the six states with the largest proportion of undocumented aliens for each fiscal year. CMS has tentatively identified Arizona, California, Florida, New Mexico, New York, and Texas as the top six states in this category. This allocation would be determined by comparing the number of undocumented aliens in the state as compared to the total number of undocumented aliens in all six states during the period July 1, 2003-June 30, 2004.

2. Eligible Providers. Medicare participating hospitals (including critical access hospitals), physicians, "providers of ambulance services," and Indian tribes are considered providers.
3. Covered Services. Hospital services would include inpatient and outpatient services required by the application of EMTALA. Coverage would begin when the individual arrives at the hospital emergency department or other area of the hospital. The coverage period would end when the individual is discharged.

Physician services would include all medically necessary services required by the application of EMTALA. This means that such services would only be covered when the individual is a hospital inpatient or outpatient. It would not include services provided in a physician's office, clinic, etc., and would not include follow-up care.

4. Submission of Enrollment Application. The proposed application process would allow the hospital to make a one-time election to either receive payments for both hospital and physician services or receive payment for hospital services and for a portion of on-call payments made by the hospital to the physicians.
5. Reimbursement from Third-Party Payers and Patients. Each provider must seek reimbursement from all available funding sources including direct payments from patients prior to requesting payment under this provision. Grants and gifts to hospitals would not be considered when making a claim.
6. Documentation of Citizenship Status. Hospitals would be required to make a good faith effort to obtain information about a patient's citizenship or immigration status prior to discharge, but after the patient is identified as a self-pay and not Medicaid eligible. The hospital would have to attest to the fact that information contained in the screening collection is correct to the best of their knowledge and abilities.

Individual level citizenship or immigration information would be maintained at the hospital level and not submitted routinely to CMS.

The hospital determination of citizenship would also apply to physician and "related" ambulance services as well.

7. Payment Methodology. CMS would adopt a bill-specific payment methodology. Medicare payment rules would be used to calculate the payment amount. All payment requests would be aggregated at the state level. Each provider within a state would receive a payment equal to the Medicare reimbursement rate or, if provider payments exceed the state allotment, providers would receive a proportional payment.
8. State Funding Pools. A single payment pool would be established for each state. This would establish a single payment allocation per state and each provider would receive a payment on a quarterly or annual basis from the state allocation.
9. Submission of Payment Request. CMS would designate a single contractor nationally for the purposes of receiving claims, calculating provider payment amounts and making payments.
10. Unobligated State Allotments. Any unobligated state funds would be returned to the U.S. Treasury.