August 16, 2004

Jim Bossenmeyer
Centers for Medicare & Medicaid Services
HAG: Mail stop: C5-01-14
7500 Security Boulevard
Baltimore, Maryland 21244

RE: Proposed Implementation Approach: Federal Funding of Emergency Health Services Furnished to Undocumented Immigrants

Dear Mr. Bossenmeyer:

The Coalition for Fair Payments to Healthcare Providers Treating Undocumented Immigrants respectfully submits the following comments on the Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), funding for emergency services provided to undocumented immigrants. The Coalition represents the American Hospital Association (AHA) and the state hospital associations of Arizona, California, Florida, Illinois, New Jersey, New Mexico, New York, North Carolina, South Carolina and Texas, as well as the Healthcare Association of San Diego and Imperial Counties and the Greater New York Hospital Association.

We appreciate the extensive effort that the Centers for Medicare & Medicaid Services (CMS) has invested in this proposal. However, there are some areas in which we would appreciate further clarification and would like to express our concern. Details are provided below.

PROPOSED IMPLEMENTATION STRATEGY

The Coalition was surprised that CMS chose not to follow the usual rulemaking process. While we understand that the agency believes it does not have formal rulemaking authority, we expected a reasonable timeframe during which to comment. We are concerned that the time provided was not adequate to thoroughly analyze the proposal and suspect that many parties that would have commented will be dissuaded. We urge CMS to seek further comment from the public once the program is underway for future possible revisions.

UNOBLIGATED STATE ALLOTMENTS

The Coalition generally supports CMS' interpretation of the law and distribution methodology. However, CMS' intention to return unclaimed reimbursements annually to the U.S. Treasury is premature. The law states that the funds "shall remain available until expended." Therefore, the unused funds should be rolled into the state allocation for the next year or reallocated to other states during the last quarter of the fourth year. This will ensure that all of the funds set aside by Congress to cover the costs of uninsured immigrants are used for these purposes.

STATE FUNDING POOLS
The Coalition asserts that the allocation of funds among the three provider types (hospitals, physicians and ambulance providers) should be set in advance and separated into distinct funding pools. We recommend that national Medicaid payment data be used as a proxy for distribution between providers. We consider this appropriate as providers that furnish services to undocumented immigrants are most often also Medicaid providers. These data are also readily available to CMS. This will ensure that one provider type will not get an unfair share of the pool if one segment is savvier at billing for the patients. Again, if funds go unspent, then they can be redistributed among the other provider types.

ELIGIBLE PROVIDERS
The Coalition is pleased that CMS has not proposed any cost or volume thresholds. We believe all providers should be able to apply for these funds and that it is the only fair and equitable approach.

COVERED SERVICES
The legislation states that funds are available for "emergency services" provided on both an inpatient and outpatient basis. We suspect that most claims will reflect "treat and release" situations of outpatient care provided in the emergency room. However, services such as surgery or intensive care provided to a patient once admitted are most often directly connected to the condition that brought the patient to the emergency room.

Thus, the Coalition supports CMS' proposal to cover those emergency and subsequent services provided through acute inpatient discharge to patients who presented with emergent conditions. Given the funds available, we understand that it is unlikely that all of the costs associated with these patients will be covered. However, including the entire inpatient stay will provide a more accurate accounting of the full costs of emergency health care services provided to these patients. It is also an easily identifiable bright line and consistent with the statutory language, whereas other points in time, such as "stabilization," are ambiguous and too difficult for CMS and providers to implement.

We would also like CMS to clarify that all emergency services are eligible for payment under this program, including pediatric and obstetric services that are not frequently billed to Medicare. Given that this patient population is very different from those served by Medicare, such services will be common and should be covered. We believe that this approach also is consistent with the law and logical as the funds are not part of the Medicare program.

DOCUMENTATION
In the proposed implementation approach, CMS states that documentation standards should: (1) not impose requirements on providers that are inconsistent with EMTALA; (2) minimize the cost and reporting and record-keeping requirements; and (3) not compromise public health by discouraging undocumented immigrants from seeking necessary treatment. The Coalition is concerned that CMS' proposed Information Collection Instrument for Documenting Citizenship (Instrument) does not meet these standards. We believe that it would have negative public health consequences and would impose a substantial burden on providers.

Public Health Risk

The first question on the Instrument would require a hospital representative to ask patients whether or not they are U.S. citizens. Subsequent questions would require hospital representatives to seek specific immigration status information. The Coalition appreciates that CMS shares our concern about detrimental affects on public health that may occur if undocumented immigrants are discouraged from seeking necessary medical treatment. However, our member hospitals believe that the questions on the Instrument regarding citizenship and immigration status will in fact be a deterrent to undocumented individuals seeking care. Individuals who are ill and decline to seek care for fear of disclosure of their immigration status to federal officials not only jeopardize their own well being by avoiding care, but may also unintentionally create a public health hazard should their illness prove to be a communicable disease. Moreover, avoiding or delaying care could hamper the identification and containment of a bioterrorism attack.

Administrative Burden

CMS states that hospitals will not be required to use the Instrument and instead may use an existing form, such as the Medicaid enrollment form, to collect the required information. CMS believes that much of the information is already collected on these existing forms and that this will minimize the burden on hospitals. However, hospitals would be required to supplement the existing form to include all of the information on the Instrument. Hospitals would have to add many of the questions to their existing process or use the Instrument to meet the documentation requirements. Therefore, little time or effort would be saved.

In its proposal, CMS appears to discount hospitals' concerns on these matters. It is important to note that the MMA 1011 proposal is targeted to undocumented immigrants, who do not generally qualify for Medicaid, with the exception of certain persons who meet specified categorical and income standards. Thus, beyond these individuals, hospitals do not complete the Medicaid-eligibility process for all patients who may be undocumented. In the minority of instances where they are eligible, patients are not currently required to attest to their citizenship status to receive emergency Medicaid services. Any requirement to answer citizenship questions or to self-attest to citizenship status would therefore be new for much of the undocumented population.

Furthermore, we believe there is relatively little benefit to querying patients directly about their immigration status. There is little doubt that patients will routinely refuse to answer (as permitted on the CMS form) or provide non-incriminating, inaccurate information. A further problem is that those patients who are in the United States on nonimmigrant visas are ineligible for Section 1011 funds. However, it should be noted that according to the Immigration and Naturalization Service (INS), approximately one-third of "unauthorized" residents in the country are persons who have violated the terms of their nonimmigrant visas and are therefore in the country illegally. Consequently, some patients who state they have a nonimmigrant visa would in fact be eligible under Section 1011. Given the high probability, therefore, that information from patients may be incomplete or inaccurate, there is little benefit to querying patients directly about their immigration status.

If CMS retains questions 1-7, the Coalition requests additional clarification about the information collection tool. Many patients — especially outpatients who are treated and released — fail to

respond to repeated hospital attempts to provide financial assistance. Under the current proposal, these suspected illegal immigrants would not qualify for Section 1011 funding because of invalid or missing information. The same logic applies to patients who simply decline to answer questions 1-7, because they fear apprehension, and may be weary of answering truthfully about their immigration status. Moreover, false identification (Social Security cards and driver's licenses) is very common in some areas. While these patients may assert that they are citizens when asked, hospitals may later find that the information provided was inaccurate. There will be many valid cases excluded without offering hospitals the ability to "screen" or set an immigration status "proxy" for patients who they believe to be illegal immigrants. If CMS insists on keeping questions 1-7, CMS should clarify that "Decline to Answer (D/A)" includes those patients who refuse to answer and patients who refuse to provide information after leaving the hospital. In addition, CMS should clarify that question 8. c. is sufficient when patients leave without answering the questions and do not respond to the customary follow up, decline to answer all of the immigration questions, or are found to have falsified their answers or identification.

Moreover, the burden on providers will not be limited to the information that would be collected from undocumented immigrants. As CMS explains in the proposed implementation strategy, Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color or national origin in any program or activity, whether operated by a public or private entity that receives federal funds or other federal financial assistance. CMS notes that providers must treat all patients the same and not single out individuals who look or sound foreign and require them to provide additional documentation of citizenship or immigration status. To comply with the Act, hospitals will be forced to ask *every* patient who receives treatment the questions on the Instrument.

CMS proposes that the individual-level citizenship or immigration information be maintained at the hospital and not routinely submitted to CMS. This is a positive step in protecting patient confidentiality, but CMS should additionally clarify that the information collected on patient immigration status will be used solely for purposes of Section 1011 and will not be shared with other agencies.

CMS proposes that a provider representative sign the application form for each Section 1011 patient to acknowledge that all information is true and complete. CMS should clarify that this can be part of the customary process for the hospital's registration and financial assistance processes and that an electronic signature is acceptable. This is particularly important given that CMS has proposed that the questions on the form can be incorporated into the current patient information collection processes of providers.

<u>Coalition Documentation Proposal</u>
The Coalition urges CMS to limit the data-collection requirements to the information that is requested in question 8 of the Instrument (See Attachment 1). Question 8 incorporates the information requirements that the Coalition suggested to CMS in our prior communications. It provides three alternatives that would allow hospitals to make a reasonable and informed decision regarding the eligibility of a patient for the Section 1011 funds. The Instrument states that completing question 8 "will help you determine whether federal reimbursement is available for a patient's care." However, it is unclear if questions 1-7 would be required in addition to question

8; or if question 8 could serve as an alternative to the other questions. **We urge CMS to allow hospitals to satisfy the documentation requirements based solely on one of the alternatives listed in question 8.**

The first alternative (presented as question 8.a. on the Instrument) provides for those patients who willingly self attest to their immigration status. In those cases no other documentation should be required. This may be used for persons who were allowed to enter by the border guards for compassionate reasons and will return to their country after receiving care. The other two alternatives (presented as questions 8.b. and 8.c. on the Instrument) would allow hospitals to make a determination based on documentation that would be checked during the customary financial screening process. The information used in the first of these alternatives would include a combination of a foreign birthplace and foreign identification documents. While we support this as an option for providers, we emphasize that providers should not have to "prove" such evidence. The other would allow a determination based on a foreign birthplace and the lack of specified information including missing or invalid Social Security number, missing or invalid U.S. driver's license, and lack of insurance, including Medicaid. These alternatives allow for a reasonable determination of an individual's eligibility without imposing a significant additional burden on hospitals. More importantly, this would reduce the risk that patients might be discouraged from seeking necessary care through fear of identification.

Documentation When Hospitals Do Not Participate

It is not clear what will happen if a hospital chooses not to participate in the program, while the physicians and ambulance providers who treat the same patients do choose to participate. Instructions should be provided to physicians and ambulance providers as to how to obtain sufficient information on the status of a patient in absence of the hospital filling out the Instrument on the patients. Hospitals that do not participate in this program must not, and we believe cannot, be compelled to collect such information on these patients.

PAYMENT METHODOLOGY/DETERMINATION OF PAYMENT AMOUNTS

The law states that CMS "may base payments for hospital services on estimated hospital charges, adjusted to estimated costs, through the applicable cost-to-charge ratio." The Coalition believes that CMS should follow this suggestion and base payments on a percent of costs rather than diagnosis-related groups (DRGs) and ambulatory patient classifications (APCs).

We believe that requiring the completion of the UB-92 and paying on the basis of DRGs is inappropriate; the Section 1011 funds are not part of the Medicare program. The prospective payment system (PPS) is intended to induce cost-effectiveness, which is not within the providers control for this population of patients. Payments based on averages will not adequately account for the wide variation in costs incurred to treat these patients. It would be more appropriate to pay all hospitals, not just the PPS-exempt hospitals, on a cost basis.

The Medicare DRG and APC systems were designed to pay for the "average" Medicare service, either inpatient or outpatient. Most undocumented immigrants receiving care in the emergency room often come in with more complex needs — largely because they lack insurance and avoid treatment. These cases are often more costly and the Medicare averaging system does not represent a similar population.

Additionally, payment under the inpatient DRGs varies widely across hospitals due to adjustments for wage index, teaching programs and disproportionate share. There is wide disparity in payment adequacy under Medicare, with the majority of hospitals losing money treating Medicare patients. With the wide disparity in Medicare payment to cost ratios, using Medicare payment will create a different base from which all Section 1011 reimbursement margin would be set. The varied payment systems of PPS hospitals, children's hospitals and critical access hospitals (CAHs) further reflect different payment levels for similar services.

Coalition Payment Proposal

While the Coalition initially pursued the possibility of a payment proxy methodology, it became clear that CMS had some major reservation about such an approach. However, we urge CMS to consider the suggested proxy approaches from other commenters to determine if those proposals, as they have been further developed, might satisfy all of the criteria in the law. **As an alternative, we propose that hospitals submit aggregate charges (which could include a roster listing of charges by case) to CMS on a quarterly basis** (See Attachment 2 and 3). The charges would then be reduced to costs using the same cost-to-charge ratio utilized for Medicare outlier payments. A percent of costs would then be set based on the volume and magnitude of the claims submitted that quarter. Hospitals would retain a patient-by-patient listing of the charges submitted that quarter sorted by account or patient ID number. CMS, or its contractor, could use this list to verify the charges through the patient's medical and billing records. Thus, the fraud and abuse portions of the law would be satisfied.

We believe that charges reduced to costs best captures the true costs incurred to providers. While there were some recent problems with high outlier payments due to the time lag in cost-to-charge ratios, this situation has been resolved through CMS' outlier rulemaking. In addition, while charges have attracted congressional and media scrutiny recently, reducing the charges to costs renders the mark-up used by the hospitals irrelevant.

The Coalition believes that using a cost-based system will bring consistency to payments for PPS hospitals, children's hospitals and critical access hospitals (CAHs), which the implementation strategy currently proposes to pay under different schemes. It would also eliminate the problem related to the adequacy of payments under the Medicare inpatient and outpatient PPS systems. Finally, it would capture the full costs for this very different patient population.

If CMS chooses to implement a cost-based approach, then we would also recommend that claims be submitted within 45 days of the end of the quarter in which the claims were *written off*. Providers would not be able to catch up in a future quarter, as they would have plenty of time to pursue other avenues of payment and include the services in the cost submission form. This would minimize the need for reconciliation. While this may delay some claims to later in the first year, the annual reconciliation would clear this up, and would be offset by the less frequent need for adjustments due to funds received from other sources subsequent to submission under Section 1011.

The Coalition would be happy to provide additional information or assistance if CMS chooses to further consider or adopt this proposal.

Physician On-Call Services
If DRGs and APCs are used to reimburse hospitals, it is unclear how physician on-call services can be claimed. Hospitals use different mechanisms to pay physicians for these services. For instance, it is common to pay a physician a stipend for the period during which they are on call. Another common mechanism is to guarantee the physicians that they will get paid the Medicare rate for those services plus a percentage (as high as 25 percent in some areas) regardless of how much the hospital ultimately gets reimbursed for that patient. Alternatively, some hospitals pay a flat per diem fee for being on-call. If CMS based payment on charges reduced to costs, these cost could be added to the claim for that patient or apportioned across patients for stipends and per diems. We do not believe that these stipends should be spread across insured patients. The stipends are paid to encourage physicians to take calls even if the patients they see are unable to pay. If the DRG and APC system is retained, then CMS will need to develop a flat-fee add-on payment or similar approach to capture these costs outside of the base payment in order to be consistent with the law and allow payment for these costs.

THIRD-PARTY PAYERS
Paragraph (c)(1) of Section 1011 requires the Secretary to reimburse providers for eligible services to immigrants to the extent that the eligible provider was not otherwise reimbursed (through insurance or others means) for such services. CMS proposes that providers seek reimbursement from all available funding sources (including government, third-party payers and direct payments from a patient) prior to requesting reimbursement under Section 1011. In cases where the payment received by the funding source does not fully cover the cost of the care provided, CMS proposes that the provider be permitted to "balance bill."

We would like to point out that in most cases, provider contracts with third-party payers indicate that the contracted payment is considered to be payment in full unless there are patient out-of-pocket costs. We believe that providers should only be permitted to balance bill under Section 1011 in cases where the patient liability is unpaid and when the third-party payer's payment is not deemed to be payment in full under the provider's contract with the payer.

Requirements to Process Medicaid Applications Prior to Requesting Section 1011 Funding
Again, providers are required to seek third-party payments before applying for payment under this section. Emergency Medicaid is available for services rendered to undocumented immigrants as long as they meet all other requirements of the state's Medicaid program. Filling out the Medicaid application is time-consuming and requires substantial documentation. It usually takes a provider many weeks to complete each application and is almost always initiated for inpatient care when the patient is in the hospital and necessary documents and attestations can be obtained through family members or others. Therefore, if an undocumented patient is admitted to an inpatient unit from the emergency department, the hospital can work with the patient and/or family to gather the necessary documents to submit with the Medicaid application. Continuing this practice seems to be a reasonable requirement before accessing Section 1011 funding.

However, CMS seems also to propose that hospitals complete and file full Medicaid applications on emergency department "treat and release" cases as well. The Coalition is extremely concerned that, as a practical matter, this requirement would create barriers to providers' accessing Section 1011 funding and defeat the purpose of the legislative program. This is because "treat and

release" patients are unlikely to be willing to submit to the questions and documentation requirements of a full Medicaid application, particularly if they are undocumented, and the presence of such a process may deter them from seeking needed care in the emergency department. Many undocumented immigrants are reluctant to provide information, much less documentation, concerning their lives because of fear that they will be reported to INS and exposed to deportation proceedings. Second, the administrative burden on hospitals to complete a full Medicaid application for these individuals would be extensive, with most hospitals unable to comply.

Moreover, in many areas, due to state or local rules, a third-party helps patients fill out the Medicaid paperwork rather than the hospital staff. In these locations, the hospitals have little control over whether the Medicaid applications are completed. The hospital can only be responsible for billing Medicaid for those patients who become enrolled. CMS proposes that hospitals and other providers use their existing practices and procedures to identify and request reimbursement from all available funding sources prior to requesting Section 1011 reimbursement. We assume this applies to all services and payers, including Medicaid and outpatient services, and that CMS does not intend for hospitals to go beyond existing policies for enrolling patients in Medicaid.

OVERPAYMENTS

The implementation plan proposes that providers be required to "immediately" notify the designated contractor in cases where it receives a payment from a third-party or patient after receipt of Section 1011 payments and to refund the monies to the contractor within 30 days.

This will place an administrative burden on the provider since there would be double notification of the payment to the contractor, once on receipt of overpayment and again when the funds are returned. The Coalition recommends that a single notification of overpayment by virtue of returning the money is sufficient. In addition, due to administrative processing and review of credit balances it would be impossible for providers to meet the proposed 30-day timeframe. Currently, the Medicare program permits hospitals and other providers to file quarterly credit balance reports and we believe this would be appropriate in this situation, as well. A quarterly submission will also correlate with Section 1011's requirement to pay providers quarterly and will further simplify the distribution and redistribution of Section 1011 reimbursement, including any necessary reconciliation. The additional complexity of third-party payments and collection of payments after Section 1011 disbursement is a key reason the Coalition is urging CMS to adopt a system based on date of write-off rather than date of service.

COMPLIANCE

The Coalition is concerned that information collected through CMS' proposed Instrument may be faulty. Thus, the signature requirement of the Instrument is worrisome. CMS should clarify that hospitals are not accountable for the accuracy of the information provided to them and are not required to validate the information. Providers should not be liable or subject to funds recovery for information that is later determined to be false, incomplete or inaccurate through no fault of the provider.

APPEALS
The Coalition also recommends that CMS use an adjustment or reconciliation process to handle overpayments rather than providers cutting checks to the contractor within 30 days. It would be far simpler for the contractor to subtract that overpayment from the next quarter's payments. If a provider does not participate in the next quarter, then the funds would be due within 30 days thereafter.

The Coalition was also disappointed to see that CMS declined to create an appeals process. Errors occur and there should be some mechanism for providers to have a claim reviewed and corrected.

ENROLLMENT APPLICATION
The proposed implementation calls for the completion of an enrollment application for providers wishing to receive payments under the Section 1011 funding for undocumented immigrants. The process outlined by CMS, however, is confusing and burdensome. First, CMS proposes that each hospital electing to receive Section 1011 payments submit an electronic enrollment application prior to submitting a payment request. The application permits the hospital to make a one-time election to either receive payments for both *hospital and physician services* or receive *payments for hospital services and for a portion of on-call payments* made by the hospital to physicians. However, the proposed implementation does not define anywhere what is meant by "a portion of on-call payments." In order for hospitals to make the necessary election as part of the enrollment, CMS should clarify the actual options available.

In addition, the proposed implementation indicates that "Any hospital, physician, or provider of ambulance services, including those operated by the Indian Health Service and Indian tribes and tribal organizations, seeking reimbursement must submit a <u>one-time</u> (emphasis added) enrollment application to participate in the Section 1011 program." While we question the need for this "one-time" enrollment application and why the submission of claims with a valid Medicare provider number would not suffice, the proposed implementation further confuses the issue by stating that "Applications by participating Medicare providers must be submitted within 30 days of the close of a Federal fiscal quarter. . . in order to be eligible to receive reimbursement for the quarter. If an application is not submitted timely, a provider would not be eligible for reimbursement for services rendered to eligible individuals for the previous quarter." This provision seems to imply the need for an enrollment application each quarter, rather than the "one-time" enrollment application also referenced by CMS. We ask that CMS clarify that an enrollment application need only be submitted once for the duration of the program.

The draft enrollment application included with the proposed implementation calls for a signature of an authorized representative. We ask that CMS specify which hospital representatives are able to sign this form. The Coalition suggests that any officers, such as the chief executive officer, chief financial officer, chief operating officer, executive vice president, or senior vice president employed by the facility or parent corporation, be authorized as is consistent with the 855 form. The draft enrollment application also calls for the Medicare Unique Physician Identification Number (UPIN) of the applicant for whom the form is completed. It should be clarified that (a) hospitals have not been assigned UPINs per se, but rather have Medicare-assigned provider numbers; and (b) since this program is expected to run through 2008, the form should reference

the National Provider Identifier (NPI) rather than, or in addition to, the UPIN. There could be some providers that do not complete the application until after the implementation of the NPI.

The form also seems to assume that all providers use the electronic funds transfer program. CMS should consider how those providers will receive the funds. In addition, it would be unnecessary for these providers to supply CMS' contractor with any changes in blanking information.

SUBMISSION OF PAYMENT REQUEST

The Coalition supports the CMS proposal to designate a single contractor nationally for the purpose of receiving and adjudicating claims submitted under Section 1011. We believe this will help to simplify the implementation and release of funds under this new program.

The proposed implementation calls for providers to submit claims within 90 days of the close of the federal fiscal quarter in order to receive payment under Section 1011. We are concerned that the requirement for claims submission, as outlined by CMS, is not only administratively burdensome on the providers, but also does not comply with the requirements under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The proposed implementation indicates, "CMS will require that a hospital file an electronic HCFA-1500 and that physicians and ambulance providers file an electronic UB-92." Currently the HIPAA transaction and code set rules require providers to bill electronically, therefore from a HIPAA compliance perspective, hospitals must bill on the 837i (the electronic equivalent of the UB-92) and physicians bill on the 837p (the electronic equivalent of the HCFA-1500). The 837i is also appropriate for claims for ambulance services furnished by providers (i.e., hospitals, skilled-nursing facilities and home health agencies), while the 837p is the required submission format for ambulance suppliers — those entities that are not owned an operated by a provider.

The proposed implementation language revises the required billing formats defined under HIPAA and therefore would violate the current law both on the part of the entity submitting the claim and the payer that accepts such a submission.

The proposed implementation is confusing since it indicates that a "claim must comply with the applicable HIPAA standard for the health care claim transaction," however, CMS' proposal introduces non-HIPAA reporting requirements that would cause providers to violate the HIPAA standard. Not only is the billing format as recommended by CMS out of compliance, but also the inclusion of new reporting requirements such as the patient's Social Security Number (SSN) as a required field on the HIPAA claim standard is a HIPAA violation. Even more troublesome is that the SSN cannot be submitted with a zero-filled or otherwise invalid number. This requirement fails to realize that undocumented immigrants are unlikely to have an SSN. Therefore it makes it impossible for a provider to comply with the reporting requirements for submitting a HIPAA compliant claim.

Presently, the HIPAA implementation guide has a series of required data elements for proper submission of the institutional claim. If the required items are not completed the provider will have their claim reject. The provider then runs the risk of penalties for violation of the standards.

Additionally, undocumented immigrants pose unique challenges to the completion of the HIPAA standard. For instance the patient address in the 2010A Loop N3 segment is a required segment that must be completed. The concern providers have is that many of these undocumented immigrants often refuse to give address information. Another requirement complicated by the HIPAA claim standard is the Payer Name in Loop 2010B segment NM1. It is unclear what the provider should report in this field. CMS should clarify if the government contractor that will disburse funds for the services provided to undocumented immigrants should be inserted.

Roster billing has been effectively used for handling special payments such as the influenza vaccine program. Consideration of a similar approach for handling the undocumented immigrants program is needed. It would simplify the process and enable providers to submit compliant information that reflects the information gathering limitations surrounding undocumented immigrants.

We urge CMS to adopt a roster-billing format, similar to that submitted previously by the Coalition and the AHA and described earlier in this letter. If such a format is not adopted, providers — whether they are hospitals, ambulances or physicians — will not be able to submit the claims necessary to receive the funds allocated for the services they provide to undocumented immigrants without being in violation of HIPAA.

PROVIDER EDUCATION

The Coalition urges CMS to release detailed instructions for providers as soon as possible. We also urge CMS to hold educational sessions for providers nationwide. In particular, we recommend that CMS include in its contract with the company that will administer this program a requirement to hold in-person training sessions in the 6 states receiving the most funds and either teleconference or web training for the remaining states. Because this is a new program that has been developed so quickly, providers are concerned about preparing their staff and systems in time. The Coalition would happily assist CMS in this effort.

CONCLUSION

The key to maximizing the benefits of this important new source of funding is to balance CMS' documentation needs with caregivers' concerns about patient confidence and unnecessary paperwork requirements that divert time and resources from patient care. The Coalition appreciates the opportunity to share our thoughts and concerns regarding Section 1011 of the MMA with CMS, and looks forward to a continued dialogue on this issue. If you have any questions, please contact Danielle Lloyd with the California Healthcare Association at (202) 488-4688 or dlloyd@calhealth.org, or Don May with the AHA at (202) 626-2356 or dmay@aha.org

Sincerely,

C. Duane Dauner

President, California Healthcare Association

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