American Hospital Association

Regulatory Advisory

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Federal Reimbursement for Emergency Services Provided to Undocumented Immigrants

A Message to AHA Members:

On May 13, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the long-awaited final implementation guidance for Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The program provides $250 million per year for fiscal years (FYs) 2005 through 2008 to reimburse hospitals, certain physicians and ambulance providers for emergency services furnished to illegal immigrants (along with a few categories of legal immigrants). This is the first time the federal government is acknowledging and directly reimbursing providers for the costs of caring for undocumented immigrants.

While there are many implementation issues, two primary areas of concern have been coverage and eligibility.

- **COVERAGE.** Payments for hospitals will be made for medically necessary emergency services from the individual's arrival at the emergency department until the patient is *stabilized*. Thus, the program will cover patients who are treated and released as well as patients who are admitted. CMS believes stabilization typically occurs within the first two days after inpatient admission.
- **ELIGIBILITY.** CMS is standing by its earlier statement that providers are *not* required to, and are not encouraged to, directly ask patients their immigration status. Instead, providers will have to answer the following three questions:
    1. Is the patient eligible, or enrolled in, Medicaid?
    2. Is the patient a Mexican citizen with a border-crossing card or has the patient been paroled into the U.S. with a form I-94?
    3. If the patient is foreign born, can any forms of foreign identification be documented that would indicate eligibility, such as foreign birth certificate, passport, voting card, or driver's license? Otherwise was an invalid Social Security number provided or did a state or federal officer bring in the patient?

  In addition, CMS will allow hospitals to generate patient identification numbers so that patient names will not have to be reported on claims, and will not require providers to routinely submit patient eligibility information to CMS. CMS has also explicitly stated that

the information provided in the claims will not be used for general Immigration and Naturalization Service (INS) proceedings.

While providers cannot yet bill under this program, patient information should be collected for services furnished on or after May 10, 2005. Providers can submit hard copy program enrollment forms now, but an electronic copy will also need to be submitted via a Web page that is not yet active. The AHA will alert members when the CMS contractor is named and ready to accept electronic enrollment applications and claims. The text of the guidance, the state allocations, the provider enrollment form and the payment eligibility form are available on the CMS website at http://www.cms.hhs.gov/providers/section1011/default.asp.

After reviewing this advisory, check off the following items from your to-do-list:

- ✓ Share this advisory with your senior management team, patient financial services directors and admitting staff.

- ✓ Download the Provider Payment Determination form (OMB No. 0938-0952) and immediately begin collecting information on the patients served.

- ✓ Prepare a Provider Enrollment Application form (OMB No. 0938-0929) and submit it once the electronic enrollment application is available.

- ✓ Work with your physicians to determine whether your hospital should bill for physician services as well. If not, download the Hospital On-Call Payment form (OMB No. 0938-0952) to bill for payments made by the hospital to physicians for on-call services.

- ✓ Ask your chief financial officer to examine the impact of this program on your 2006 revenue.

The AHA will continue to monitor the implementation of this program to ensure that access to care is not hindered, and to work with CMS to ensure that the administrative burden of the program is minimized.

Sincerely,

Rick Pollack
Executive Vice President June 29, 2005

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Background

On May 13, the Centers for Medicare & Medicaid Services (CMS) published in the *Federal Register* the long-awaited final implementation guidance for Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). The program provides $250 million per year for fiscal years (FYs) 2005 through 2008 to reimburse hospitals, certain physicians and ambulance providers for emergency services furnished to illegal immigrants (along with a few categories of legal immigrants). This is the first time the federal government is acknowledging and directly reimbursing providers for the costs of caring for undocumented immigrants.

The Emergency Medical Treatment and Labor Act (EMTALA) mandates that hospitals treat anyone who needs emergency care, including undocumented immigrants, regardless of their ability to pay for that care. Before the Section 1011 provision became law, the federal government only paid for the medical care of undocumented immigrants who were in Immigration and Naturalization Service (INS) custody. A 2002 study by the United States-Mexico Border Counties Coalition found that the costs of providing emergency care to undocumented immigrants was saddling already strapped border hospitals with about $200 million in unpaid bills. Since then, the problem has been exacerbated by the growing numbers of undocumented immigrants coming to the U.S. and their lack of regular health care. Recognizing that the costs of providing care to undocumented immigrants were becoming burdensome to many hospitals, particularly along the southern border, Sen. John Kyl (R-AZ) proposed Section 1011 of the MMA.

To receive payment, patient information should be collected for services furnished on or after May 10, 2005. Providers can submit hard copy program enrollment forms now, but an electronic copy will also need to be submitted via a Web page that is not yet active. The AHA will alert members when the CMS contractor is named and ready to accept electronic enrollment applications and claims. The text of the guidance, the state allocations, the provider enrollment form and the payment eligibility form are available on the CMS Web site at www.cms.hhs.gov/providers/section1011/default.asp.

Eligible Providers

Hospitals
All Medicare participating hospitals (general acute, psychiatric, rehabilitation, etc.) are eligible for the 1011 program, including Indian Health Service facilities (whether operated by the Indian Health Service or by an Indian tribe or tribal organization) and Medicare critical access hospitals.

Physicians
Unlike the policy for hospitals, physicians do not need to be Medicare participating providers. Doctors of medicine, doctors of osteopathy, and – within certain statutory restrictions on the scope of services they may provide – doctors of podiatric medicine, doctors of optometry, chiropractors, or doctors of dental surgery are all eligible to participate in the 1011 program.

Ambulances
Ambulance providers that are licensed by the state to provide emergency transportation services are eligible for payment for covered transports to a hospital emergency department or from one hospital to another.

Other Providers
Other providers and practitioners such as Federally Qualified Health Centers (FQHCs) and mid-level practitioners, including nurse practitioners, physician assistants, and clinical nurse specialists, are not eligible for the program.

State Allotments
Two-thirds of the funds allotted to the program – or $167 million – will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented immigrants. One-third, or $83 million, will be divided among the six states with the most undocumented immigrant apprehensions. The pool of funds based on apprehensions may change annually and will be recalculated at the beginning of each fiscal year. Attachment 1 contains the final state funding allocations for FY 2005.

Unobligated State Allotments
The law clearly states that the funds "shall remain available until expended." CMS has thus determined that any unspent funds will roll over to the next program year rather than being returned to U.S. Treasury as initially proposed. However, CMS does not believe that it has the authority to shift unspent money from one state to another.

Covered Services
While the proposed program guidance covered all services provided through inpatient discharge for patients admitted through the emergency department, the final program guidance indicates that payment will only be available for medically necessary emergency services from the individual's arrival at the emergency department until the patient's *stabilization*. Thus, the program will cover both patients who are treated and released and patients who are admitted; however, it will not cover the entire patient stay at the hospital. CMS believes stabilization typically occurs within the first two days after inpatient admission and that claims for longer inpatient stays will be subject to review for appropriate documentation. In addition, CMS indicates that it will allow hospitals that receive an appropriate transfer under EMTALA to claim

reimbursement for services provided from the time the patient arrives until the patient is stabilized.

CMS is using the definition of "stabilized" currently utilized under EMTALA and defined in regulation at 42 CFR 489.24(b). Under EMTALA, the term stabilized means that a patient can be transferred (transferred to another hospital or released) without material deterioration of the patient's condition either during or as a result of the transfer. It does not require resolution of the underlying medical condition. Rather, it is the emergency medical condition that caused the individual to seek care that must be resolved.

Claims Eligibility

While CMS initially proposed that providers directly ask citizenship status, CMS later backed down from this position in response to the outcry from providers, congressional offices and immigration consumer advocacy organizations. CMS is standing by its October 1, 2004 statement that providers are neither required nor encouraged to directly ask patients their immigration status. Instead, providers will be required to determine patient eligibility by establishing the following through indirect questions:

1. Is the patient eligible for, or enrolled in, Medicaid or emergency Medicaid?

2. Is the patient a Mexican citizen with a border-crossing card (i.e., laser visa, Form DSP-150) or has the patient been paroled into the United States at a United States port of entry with a Form I-94 that is stamped with term "Parole" or "Parolee"?

3. The combination of a reported foreign place of birth **and** verification can be used as an affirmative demonstration of eligibility. A photocopy of any documentation obtained must be attached to establish payment eligibility. Providers must demonstrate at least one of the following and obtain verification in order to submit an individual payment request.

    a. Foreign birth certificate, a foreign passport, a foreign voting card, an expired visa, invalid border crossing card, foreign driver's license, a "Matricula Consular," or other foreign identification card.
    b. Submitted Social Security Number (SSN) is invalid.
    c. Federal or State officer/agent custody.

This information is captured on the model Provider Payment Determination form (OMB No. 0938-0952) that may be used to determine a provider's eligibility for payment for a particular patient and is available at www.cms.hhs.gov/providers/section1011/cms-10130A.pdf. Providers may integrate this information into their current systems as long as all of the information is collected, documented, and maintained for possible review during audit or compliance review. For instance, similar information is included on some states' Emergency Medicaid forms. Providers could use that documentation to verify some of the information and then use a supplemental form to record the additional required information.

CMS maintains that all other possible forms of reimbursement must be exhausted prior to billing the 1011 program as described in more detail under third-party payments. Thus, providers will need to fill out Medicaid or Emergency Medicaid applications for all patients who may be

eligible for those programs. This includes patients who are seen in the emergency department and are never admitted. If the patient is eligible for Medicaid, the person filling out the form should continue through the other questions. Thus, the information necessary to support a 1011 claim would be available in the event that a patient were later determined to be ineligible for Medicaid, or the provider chose to bill the 1011 program for the unreimbursed copay and/or deductible. (This is a change from CMS' original form, reflected in a new notice issued June 24, 2005.

Note: *providers are not able to bill for patients if the necessary information is not collected.* However, in recognition that this will occur fairly often, CMS has included a provision to increase by 10 percent every approved claim. This add-on, however, would be subject to a pro rata reduction.

As CMS explained in the proposed guidance, 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 should follow their normal intake procedures including determining Medicaid/Emergency Medicaid eligibility and place of birth, and then proceed with the remainder of the required 1011 program questions.

In addition, CMS will allow hospitals to generate patient identification numbers so that patient names will not have to be reported on claims, and will not require providers to routinely submit patient eligibility information to CMS. Moreover, CMS has explicitly stated that the information provided in the claims will not be used for general civil proceedings like INS deportation efforts, but may be obtained by the Department of Homeland Security in the rare event that major criminal proceedings involve an immigrant served under this program.

The AHA will monitor the implementation of this program to ensure that its procedures do not interfere with patient care or cause any unintended public health consequences.

Third-Party Payers

The law requires the Secretary to directly reimburse providers for eligible services to undocumented immigrants to the extent that the eligible provider was not otherwise reimbursed (through insurance or other means) for such services. CMS requires providers to 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 some cases, CMS will allow providers to bill the 1011 program for the balance of what was not covered by a third-party funding source. Below is a list of the eligible costs for which providers can bill after receiving third-party reimbursement.

- ***Medicaid Payments*** are considered payment in full and providers are only allowed to submit a request for Section 1011 reimbursement for the deductible, coinsurance or co-payment not paid by the individual.

- ***Department of Homeland Security Payments*** are considered payment in full.

- ***Workers Compensation Cases,*** subject to limitations imposed by state law, may be billed to Section 1011 for unpaid workers' compensation co-payments and deductibles after seeking payment from the patients.

- ***Self-pay Patient Cases*** – when patients are unable to cover their entire bill, the remaining portion may be submitted to the 1011 program once it is established that there is no third-party payment available.

- ***Grants and Gifts,*** such as state and local indigent or charity care programs or state-funded subsidies, are not to be considered in determining whether a third-party payment is applicable.

- ***Medicare Cost Report*** should not reflect Section 1011 payments.

Enrollment Application
CMS is requiring providers to submit a one-time Provider Enrollment Application form (OMB No. 0938-0929) that can be found at www.cms.hhs.gov/providers/section1011/cms-10115.pdf. This is a one-time application that does not need to be resubmitted unless the information furnished by the provider changes. Hospitals have the choice of billing on behalf of just the hospital or for physicians as well. If the hospital elects to bill for physician services as well, the hospital must bill for all Section 1011 physician services provided in the hospital and physicians will not be allowed to bill separately. If the hospital does not bill for the physicians, it may claim the costs of reimbursing physicians for on-call services using the Hospital On-Call Payment form (OMB No. 0938-0952).

If a hospital participates in the program, it must collect and share the patient eligibility information available with the physicians and the ambulance providers. If a hospital chooses not to participate in the program, then the physicians and ambulance providers will be expected to collect the information on their own. While one of the published applications specified that hospitals would have 30 days from the date of service to provide the eligibility information to physicians and ambulance providers, it has been corrected to state 120 days.

The enrollment application must be submitted in both hard copy and electronic form. While providers are welcome at this time to submit the hard copy to CMS, the electronic form is not yet available. This will become available shortly after the administrative contractor is named.

Claims Submission
Nationally, there will be one administrative contractor for enrolling providers, receiving claims, and making payments. Providers will have 180 days after the end of the quarter in which services were rendered to submit electronic claims for payments. Claims received after that time will not be paid.

Unless specifically requested, providers should maintain, but not submit, medical and/or patient eligibility information. The administrative contractor may review claims documentation prior to making a Section 1011 payment, and the compliance review contractor may review claims documentation during the compliance review process to determine the accuracy of payments.

If a provider submits a Section 1011 claim to an existing Medicare carrier or fiscal intermediary other than the designated Section 1011 contractor, the claim will be returned. Since Section 1011 claims are not Medicare claims and will not contain a valid Health Insurance Claim Number, only the designated contractor will be able to process these claims to payment.

Payment Methodology

While 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," CMS has chosen to base payments on claims submitted in a process similar to Medicare. Hospitals will be required to electronically submit claims on the X12N 837 i (electronic version of the UB92), while physicians will use the X12N 837p (the electronic version of the CMS 1500). Claims should follow Medicare billing rules, like bundling outpatient services provided within 72 hours of admission, and will be reimbursed based on a portion of diagnosis-related groups (DRGs) and ambulatory patient classifications (APCs). Moreover, CMS will use the Medicare inpatient prospective payment system transfer policy to calculate payment for inpatient claims.

Below is a list of the payment policies for other types of hospitals and providers:

- Payment rules using the transfer payment policy under the inpatient PPS for long term care hospitals (LTCHs);
- Payment rules using the inpatient psychiatric facilities (IPF) PPS for hospitals transitioning to the IPF PPS to calculate what Medicare would have paid on a per-diem basis for the days up to and including the date of stabilization;
- Payment rules using the transfer payment policy under the inpatient rehabilitation facility PPS;
- The interim payment on the bill for inpatient services provided by critical access hospitals (a per-diem amount for routine services and a percentage of billed charges for ancillaries services);
- The TEFRA per discharge limit for children's and cancer hospitals excluded from the IPPS;
- Payment rules under the Outpatient Prospective Payment System (OPPS) for hospital outpatient department emergency-related services;
- Payment rules under the physician fee schedule for Medicare participating physicians (that is, service level billing using appropriate CPT/HCPCS codes that will then be converted to claimed payment amounts using the Physician Fee Schedule (PFS) payment rules appropriate for the services billed). Similarly, physicians not enrolled in Medicare will receive the PFS payment amount;
- Payment rules under the ambulance fee schedule for ambulance trips that would be separately payable under the Medicare program if the patient were a Medicare beneficiary. Consistent with Medicare policy, the point of pickup determines the basis for payment under the fee schedule and is reported by its five-digit zip code. Thus, the point of pickup zip code determines the level of payment under fee schedule and applicable geographic practice costs index (GPCI). If a second ambulance transport is required for a subsequent transport, then the zip code of the point of pickup of the second or subsequent transport determines both the applicable GPCI for that leg and whether a rural adjustment applies to that leg.

Implementation Delay
While the program was expected to begin October 1, 2004, it was delayed until May 10, 2005. CMS will account for this delay in two ways. First, the $125 million that should have been available during the first two quarters of FY 2005 will be dispersed during the second two quarters of FY 2005. Given that the funds available are not expected to fully cover provider costs and CMS will allow unused funds to roll forward to the next year, it is not anticipated that this method will leave funds unspent.

Second, since CMS was unable to release the guidance prior to the April 1 beginning of the quarter, CMS plans to calculate an average claim per day based on submitted claims between May 10 and June 30, and multiply that by the total number of days in the quarter. For example, if $50,000 worth of claims are approved for a particular provider for dates of service between May 10 and June 30 ($50,000/52 days) the average claim per day would be $961.54. CMS will multiply this figure by 91 days as that is the actual number of days in the third quarter of FY 2005 (91 X $961.54), which yields a total payment for the quarter of $87,500.14 rather than the $50,000 submitted. However, continuing this example, a pro-rata reduction may also be employed if there are not enough funds available to cover all of the claims submitted. Thus, it is possible that only a percentage of this total figure would be reimbursed.

Pro-Rata Reduction
The law requires CMS to make a pro-rata reduction to payments if the total funds available are insufficient to meet total obligations under the program. When this happens, CMS will recalculate payments to ensure that the same portion of each participating provider costs are covered in a state. For example, if total claims in a particular state equal $50 million and only $10 million is available in that state, each provider will receive 20 percent of its costs. CMS notes that this reduction will vary from quarter to quarter and from state to state.

Overpayments
The guidance requires a provider 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. If the hospital receives funding the following quarter, the administrative contractor will reduce those payments by the overpayment. If the provider does not receive payments the next quarter, the administrative contractor will notify the provider that the overpayment is due within 30 days of the receipt of the notification letter.

Reconciliation
At the end of each fiscal year, CMS will conduct a reconciliation process if additional funds are available for distribution. For example, overpayments due to third-party reimbursement that have been collected throughout the year will be disbursed during the year-end reconciliation. CMS will have mechanisms in place to ensure that the claims payments do not exceed the funds available, thus there should be no need to recoup payments at the end of the year.

Compliance
CMS will designate a compliance contractor that will review medical and non-medical documentation. The compliance contractor may conduct pre-payment or post-payment claim reviews, identify and assess overpayments and ensure compliance with the provisions outlined in

the guidance. CMS will be developing an informal appeals process for providers that wish to contest the results of such reviews.

Disproportionate Share Hospital Payments

While there was discussion during the development of the guidance over whether Section 1011 funds would offset disproportionate share hospital (DSH) funds dispersed through State Medicaid programs, CMS has not indicated such an offset in the final guidance. However, CMS may seek additional comments on this issue at a later date and implement an offset in the future. Providers should apply regardless as there is no obligation to bill and providers should have sufficient warning of any offset.