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NATIONAL COUNCIL OF LA RAZA

August 16, 2004

Mr. Jim Bossenmeyer
Centers for Medicare & Medicaid Services
Center for Medicare Management, Hospital Ambulatory Group
Mail Stop C5-01-04
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Dear Mr. Bossenmeyer:

The National Council of La Raza (NCLR) is pleased to offer comments regarding the implementation proposal set forth by the Centers for Medicare and Medicaid Services (CMS), which implements Section 1011 of the Medicare Modernization Act of 2003 (MMA).[1]

NCLR is the largest national constituency-based Latino civil rights organization in the country, representing over 300 community-based organizations throughout the U.S. which serves more than four million Hispanics annually. Our mission is to reduce poverty and discrimination and improve life opportunities for Hispanic Americans. NCLR believes that the proposal offered by CMS to implement section 1011 of the Medicare Modernization Act is detrimental to Latinos and has significant potential to endanger their lives. The proposed methodologies to collect identifying information, including immigration status, as a stipulation of hospital reimbursement would be a deterrent to Latinos and immigrants seeking emergency health care. This commentary serves to address our concerns with the current proposal.

In summary, NCLR feels that CMS has misinterpreted the original intent of the proposal. We hope that CMS will reconsider a proxy-based methodology, which provides advanced reimbursement to hospitals receiving funds based on statistical analysis, such as Medicaid data. NCLR is of the opinion that this is the best technique both to minimize hospital burden and serve the interests of all patients seeking emergency treatment. Finally, we hope that CMS will retain the portion of the proposal, which discusses covered services.

[1] Public Law 108-173.

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DOCUMENTATION

Direct Patient Inquiry

NCLR is alarmed that the current proposal requires health care providers to collect, record, and maintain the immigration status of emergency room patients. The suggested methodology for collecting information would contribute to discrimination in health care settings, amplify disparities in health, and increase burdens on providers that are already stretched thin. NCLR feels that inquiries about immigration status would serve as a deterrent to immigrants and their families regardless of their status, and prevent them from seeking critical urgent care. It is also essential to remember that policies such as this have a direct affect on citizen children with immigrant parents. Approximately 85% of immigrant families are composed of mixed-status families, each comprising at least one immigrant parent and one citizen child.[2] Deterring immigrants from emergency care also hinders citizen children from accessing emergency care since their parents will be afraid to access services. Immigration laws are extremely confusing, and immigrants, regardless of status, would avoid treatment if asked their immigration status coupled with other identifiers such as name, address, and phone number, for fear that it would cause deleterious immigration consequences, including deportation and separation from children and family members, inability to become a U.S. citizen, and inability to sponsor family members.

Deterring immigrants and their families from seeking health care not only undermines the health and well-being of the cornerstone of our infrastructure and low-wage workforce but poses a looming public health threat to our nation. Immigrants and their families are integrated within our society, and it is unwise to deter a significant portion of our population from accessing health care that could prevent the spread of communicable diseases. Particularly at a time when our nation faces the risk of biological terrorism, any proposal that hinders access to emergency rooms counters our country's mission to secure the well-being of our residents. Many immigrants who would be impacted by this proposal prepare our food source, take care of our children and parents, and otherwise interact with us every day.

Further, requiring patients to provide their immigration status is likely to produce flawed results in comparison with alternative documentation methodologies. Documentation paperwork is likely be unfinished and inaccurate, due to among other things, lack of patient understanding of the document and user error, a patient's incomplete understanding of a document's purpose, improperly trained health staff, and fear of identifying one's self as an undocumented immigrant. Using the self-attestation of undocumented alien status is extremely inaccurate. Undocumented aliens not only would be reluctant to self-declare their status, but they also may not be aware

[2] Urban Institute, *The Integration of Immigrant Families in the United States* (July 2001)

they are categorized as undocumented. Please refer to the subsection "Proxy Methodology" for our alternative proposal.

Administrative Burden

In addition to the widespread confusion and fear that would be pervasive in immigrant communities, the administrative burden under the CMS proposal would far exceed the practicality of implementing Section 1011. Under such a proposal, significant time would have to be dedicated to probing patients for sensitive information. Hospitals would incur many additional costs because of the technology needed to maintain such an extensive data set. In addition, since health care workers have a small knowledge base of immigration law, hospital workers would have to undergo extensive training with background on immigration and citizenship terminology.

Title VI of the Civil Rights Act of 1964 provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[3] **Unless health care providers receiving funds under Section 1011 collect immigration status from all individuals prior to emergency room discharge, they would be in violation of Title VI. NCLR recommends that the prohibition of discrimination be reiterated in a final CMS proposal.** We are concerned that this proposal foments racial profiling and discrimination. For instance, as reported in the May 2004 General Accounting Office report, a hospital used the absence of a Social Security Number (SSN) and Hispanic status to determine that a patient was undocumented even though the absence of an SSN is not an indictor of immigration status.[4] NCLR is concerned that hospitals, in their efforts to avoid heavy paperwork loads, will inadvertently racially-profile Latinos and other communities of color, and target these populations for collection of information.

Proxy Methodology

NCLR strongly suggests that CMS employ a proxy-based methodology to determine reimbursement to providers for emergency care given to undocumented patients. We feel that this is the only method explored by CMS, which will prevent this provision from becoming an administrative burden, while protecting patients and preserving the patient-doctor relationship. In addition, we feel that this is the most effective method to maximize appropriate reimbursement to providers.

As a more accurate, cost-effective methodology for determining allowable costs, CMS should allow providers to use available emergency Medicaid data for undocumented immigrants to

[3] Public Law 88-352; http://www.justice.gov/crt/cor/coord/titlevistat.htm
[4] United States General Accounting Office, *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs* (May 2004)

determine their allowable costs. Under this approach, a provider would determine what percentage of its total Medicaid patients are those patients who receive emergency Medicaid services. This percentage would then be multiplied by the provider's total uncompensated costs for the most recent available period. In effect, this approach assumes that, if undocumented aliens make up 4% of all Medicaid patients served by a provider, then they also account for the same percentage of the provider's total uncompensated costs. Physicians and ambulance companies would apply the undocumented Medicaid percentage to their total aggregate uncompensated costs for a recent time period, as determined by CMS. This would avoid requiring providers to determine not only the immigration status of millions of patients nationally, but also patient-specific costs and offsetting revenues for individually identified undocumented immigrants.

NCLR does not believe that an indirect proxy (e.g., certain foreign documents or missing U.S. documents) would be effective in recounting for determining undocumented immigrants eligible for Section 1011 reimbursement because it would err on the side of overcounting rather than undercounting undocumented immigrants. In addition, total available funding is capped at a level so that the net effect of increasing total allowable costs would be that an even smaller percentage of total allowable costs would be reimbursed. Instead, the ultimate net fiscal impact of using the indirect proxies would be to further reduce the net financial benefit of the program because, while overall funding would continue to be capped at $250 million a year, administrative costs would increase. Administrative costs would increase because counting more emergency patients as undocumented immigrants will increase the number of patients for whom costs and offsetting third-party reimbursements would have to be tracked and reported. Another real danger is that it would increase the risk of audit exceptions, as it will be administratively complex to identify Medicaid payments for claimed patients.

Proposed Information Collection Instrument for Documenting Citizenship – Attachment B

CMS' proposed information collection instrument would provide unreliable results. It is impossible to demonstrate that a person is undocumented using the information collected on the instrument (Attachment B). One example pertains to immigrant patients holding a student visa. Under the proposal, providers could not obtain reimbursement for a person who holds a student visa. However a student who has overstayed the dates of his or her I-20 form, but still possesses a visa, would technically be undocumented and therefore a hospital could seek reimbursement. In addition, absence of a Social Security Number (SSN), "greencard," or withholding information does not indicate the undocumented status of a patient.

COVERED SERVICES

NCLR concurs with the CMS decision to cover the scope of patients' services from beginning of treatment until discharge. Coverage until discharge will allow providers to

discern the best possible medical treatment for patients, without the administrative burdens of split billing for services provided. In addition, it will ensure that providers are able to follow the guidelines established under the Emergency Medical Treatment and Active Labor Act (EMTALA).

INFORMATION REQUIREMENTS

In general, NCLR is very concerned with the expedited timing of the comment period for this proposal and method in which this proposal was distributed. Although the information was made available on the CMS website, there were no announcements through standard public notice venues such as the *Federal Register*. This limited the ability of many organizations, lawmakers, and other interested individuals both to analyze the impact of this proposal and to assess its total impact. Considering the possible implications of distributing $1 billion in federal funds, we hope that CMS will be seeking additional public input as part of the Paperwork Reduction Act (PRA) process.[5] Specifically, we urge that CMS solicit commentary on a cost-benefit analysis of alternative documentation methodologies. We believe that further analysis will show that a process by which individual patients would be queried about their status would be in disagreement with the PRA.

If you have any questions, please contact Jennifer Ng'andu at (202) 776-1762 or jngandu@nclr.org.

Sincerely,

Raul Yzaguirre
President

Enclosure:

NCLR's ORAL Comments Provided at the CMS Open Door Forum Session August 2, 2004.

C.C.:

John D. Graham, Administrator
Office of Management & Budget, Office of Information & Regulatory Affairs

The Honorable John Kyl (R-AZ)

[5] http://www.whitehouse.gov/omb/inforeg/pra_memo111401.pdf

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I'm Jennifer Ngandu, Health Policy Associate, with the National Council of La Raza. The National Council of La Raza (NCLR), headquarted in DC, is the largest national constituency based Latino civil rights organizations in the nation, representing over 300 community based organizations throughout the US and having a reach of nearly 4 million.

NCLR appreciates the opportunity to provide our input regarding this proposal and its implications toward our nation's nearly 40 million Hispanics.

NCLR is extremely troubled that as currently drafted, the proposal would discourage immigrants and their children and families - regardless of status -- from receiving emergency medical care. Of particular concern is the planned patient-based approach for collecting immigration status described in section IX, "Documentation of Citizenship Status."

This approach, whereby patients are asked for their name, address, phone number, coupled with numerous probing immigration questions, will undoubtedly frighten immigrant communities. Regardless of their immigration status – whether undocumented or not - they will fear that this extremely personal information could be used against them, and cause their deportation & separation from children and family members, inability to become a US citizen, and failure to sponsor family members. Further, we are concerned that the Center for Medicare and Medicaid Studies (CMS) did not include protections that prevent patient information being shared outside of CMS.

Undocumented patients do not live in isolation. 85% of immigrant families are of composed of citizens and non-citizens, undocumented and documented alike. It is likely that the immigrant parents of citizen children will be terrified to seek care for their children, let alone themselves.

Furthermore, because immigration status cannot be easily determined, health care providers would face the possibility of asking every patient who is uninsured and ineligible for federal programs about their immigration status. This would increase the paperwork burden for health care providers, who are already overextended. In efforts to relieve the stress of this onerous data collection, some health professionals may seek to identify undocumented patients based on outward appearances. We believe that Latinos could be unfairly targeted under the conditions of this proposal.

NCLR cannot condone the collection of immigration status in emergency situations, even if it takes place after receiving care. Once these questions documenting both identifying information with immigration status, it is an absolute that fear will be created in patients. They will pass on to other community members that whenever they go to the hospital, even if it is a critical emergency, the hospital will ask and collect this information. Unfortunately our public health will bear the burden of creating this "chill factor" in immigrant communities – where immigrants

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and their children will not receive care resulting in severe preventable illness, death and spread of communicable diseases.

NCLR strongly urges the Centers for Medicare and Medicaid Studies (CMS) to reconsider a proxy-based methodology to determine reimbursement. A proxy-based methodology would minimize the administrative burdens to hospitals – allowing health professionals to dedicate more time to treatment of their patients, eliminate fear and confusion within immigrant communities, and remove any motivation for civil rights violations.