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August 13, 2004

Jim Bossenmeyer
Centers for Medicare & Medicaid Services
Center for Medicare Management, Hospital and Ambulatory Group
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 FY 2005-2008**

Comments to Part IX – Documentation of Citizenship Status

Dear Mr. Bossenmeyer,

The National Health Law Program is a public interest law firm working to increase and improve access to quality health care on behalf of limited income people through legal analysis and representation, information, education and policy advocacy. With offices in California, North Carolina and Washington, D.C., NHLP provides specialized assistance on indigent health care matters to attorneys, community-based organizations and national and state policy makers throughout the country. We write this letter of comment in response to your recent proposal regarding documentation requirements for providers seeking reimbursement for care provided to undocumented immigrants pursuant to section 1011 of the Medicare Modernization Act.

As the topic at hand concerns the care given by doctors and other providers to some of this country's most vulnerable residents, we believe that CMS should be guided by the medical profession's overriding obligation, which is to "First, do no harm." We recognize that you must sort and weigh a number of complex, interrelated and sometimes contradictory factors in deciding how best to administer the section 1011 funds, but that fact is exactly why it is so important to adopt the position of doing no harm.

Section 1011 of the Medicare Modernization Act (MMA) exists to reimburse providers who provide a necessary and invaluable service by caring for those who, when they present, are always sick, usually uninsured and sometimes without documentation of their immigration status. Congress provided these funds not only to recognize and partially compensate for the work that is now being done, but certainly also to encourage the continued provision of this care. It is not only humane, but also critical to our public health, that everyone who is seriously ill receives help. The documentation regimen adopted by CMS should recognize this dual purpose, and err on the side of ensuring that no one is dissuaded from seeking treatment by the documentation that providers must collect to get reimbursed for that very care. A system that does not accomplish that end is one that would increase rather than decrease the risk of a public health emergency. The tuberculosis bacterium, for example, does not recognize a person's immigration status as it spreads throughout a community, which is, along with our humanitarian

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instincts, presumably one of the principle reasons why we offer care to all those who are present in our country, regardless of their immigration status.

The idea that CMS should err on the side of doing no harm is reinforced by the recognition that the section 1011 funds will be grossly inadequate to compensate for the care that is presently being provided. This reality means that CMS need be less concerned with precision than might otherwise be the case. If it is acknowledged that a hospital or other provider is only going to receive reimbursement for only 25%, or even 50%, of its expenditures on behalf of undocumented immigrants, CMS should be comfortable with a much larger margin of individual eligibility error than if full payment were contemplated. Why is it essential to insure that not a single ineligible individual is served with section 1011 funds when CMS recognizes that the providers will be serving far more eligible people for whom they will receive no reimbursement?

Thus, CMS should not even attempt to create a system that results in no positive errors. First, no such system is possible. Second, the time that providers will spend in pursuit of such an ephemeral goal is certainly better used treating the people for whose care this money was intended. Third, as any system pushes the positive error rate lower, it will inexorably increase the negative error rate, which in this case is measured by the number of sick immigrants who forego needed care because they are more afraid of being arrested than they are of being ill or even, to the detriment of all of us, contagious. Given that the shortage of funds guarantees that for every ineligible person treated there will be one, or three, or eight eligible patients for whom the providers receive no payment at all, CMS should not seek a system that strives to achieve a perfect match between payment and eligibility. Rather, it should have as its goal a system that, first and foremost, discourages no one from seeking care, while providing verification that is sufficiently accurate to insure that no provider, in the aggregate, receives more section 1011 reimbursement than it deserves.

We believe that the flexibility afforded CMS by the recognized inadequacy of the section 1011 funds should be passed along to the very providers that will have to implement the final system. We suggest therefore that CMS reconsider its position on the various documentation suggestions offered by those providers. Collecting information or documentation that acts as an approximate surrogate for immigration status, without ever inquiring directly into that status, is a reasonable and sufficiently accurate approach in the current context. It simply does not matter if that surrogate information is occasionally over-inclusive, for in the final analysis every provider will receive only a percentage of its costs for serving the target population.

If CMS is not willing to accept the concept of surrogate documentation, then it should at a minimum adopt the one-time sampling method suggested by the Center on Budget and Policy Priorities. It is true that sampling, like the method being proposed by CMS, has the drawback of directly asking questions about a person's immigration status, which may violate the precept of doing no harm by dissuading those who need care from seeking it. But, unlike the system proposed by CMS, it would be a one-time event that could be largely dissociated from the care being provided. Because the survey would not be perceived as a *quid pro quo* for the care, the responses to it are more likely to be accurate. And because all emergency room users could be surveyed for a fixed period of time, potential Title VI and EMTALA difficulties that will inevitably arise under the proposed system can be avoided.

For these reasons, NHeLP urges CMS to adopt one of the surrogate documentation regimens suggested by the hospitals or other providers. Short of that, a one-time survey method should be utilized. But any mechanism adopted must first and foremost meet the requirement that it do no harm. In the current context this means embracing a system that does not sacrifice needed care in the quest for ultimately unnecessary precision. Thank you for your consideration of these comments.

Sincerely,

Steve Hitov, Managing Attorney