

August 16, 2004

Jim Bossenmeyer  
CMS  
Center for Medicare Management  
Hospital and Ambulatory Group  
Mail Stop C5-01-14  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Letter also submitted by email 08/16/04**

Dear Mr. Bossenmeyer:

The Association of American Medical Colleges represents approximately 400 of the nation's major teaching hospitals and health systems, all 125 accredited allopathic medical schools, 96 professional and academic societies, and the nation's medical students and residents. We welcome the opportunity to comment CMS's *Proposed Implementation Approach: Federal Funding of Emergency Health Services Furnished to Undocumented Aliens: Federal Fiscal Years 2005 Through 2008*.

**Failure to Issue a Proposed Rule**

CMS is seeking to implement a provision that is part of the Medicare Modernization Act (MMA), enacted into law in December 2003. The law requires that "no later than September 1, 2004, the Secretary shall establish a process under which eligible providers located in a State may request payments . . ." for emergency health services furnished to undocumented aliens. "We recognize that the MMA has required CMS to implement many provisions within a relatively short timeframe, admittedly a very difficult task. Nonetheless, we believe that these rules still require compliance with the Administrative Procedures Act so that all interested parties have an opportunity to comment, and the agency has an opportunity to consider and respond to each comment. We disagree with the conclusion of CMS that "section 1011 does not delegate legislative rulemaking authority to the Secretary." This provision should be implemented through a formal rulemaking, as required by the Administrative Procedures Act.

**Third Party Reimbursement**

CMS is proposing that "each provider seek reimbursement from all available funding sources . . . prior to requesting reimbursement under section 1011." CMS also is allowing providers to "balance bill" for

any amounts not paid fully by another insurer. Presumably the “balance billing” also must occur before a claim can be submitted to the fund. CMS further proposes that if a claim is not submitted within 90 days of the close of the Federal fiscal quarter, it will be denied.

It seems likely that most undocumented aliens will have no source of payment for care available to them. By requiring providers to seek reimbursement before applying to the fund, and simultaneously requiring that all claims be submitted within 90 days of the end of the quarter, CMS may make it impossible for many providers to submit claims to the fund. It may well take over 90 days after the end of the quarter to make a reasonable determination that no other funding sources are available, by which point it would be too late to submit a claim. CMS either should be willing to accept a provider’s attestation that it has a reasonable belief that no other funding sources are available, or providers should be able to submit claims after the 90 days if the reason for the later submission is that the provider was attempting to get payment from other sources.

An additional requirement is that if a provider receives a payment from a third-party payer or a patient after a payment request has been submitted, then CMS’s designated contractor must be notified immediately . If a payment has been made, the provider may be assessed an overpayment. Also, if a payment were made, any money would have to be returned to the CMS contractor within 30 days of receipt of the third-party payment. Particularly for a large teaching hospital or health system, it may take a while for the billing system to reconcile payments received from various sources for the same services or services. A provider should be allowed a reasonable period of time—a minimum of 90 days—from the point at which it becomes aware of the duplicate payment until it must notify the contractor of a third party payment and reimburses the funds. Unless a provider is acting in bad faith, overpayments should not be assessed.

Finally, the AAMC requests that CMS state that disproportionate share (DSH) payments are not considered to be payments by a third party or balance billing. We support the National Association of Public Hospitals’ assertion that Medicaid DSH payments are similar to the non-patient specific “grants and gifts to hospitals” already excluded from counting towards balance billing and third party payments in the proposal. The failure to clarify DSH payments as separate from patient specific “third party coverage” could result in an overall decrease in payments to certain hospitals, which is not the intent of the provision.

### **Documentation**

The AAMC strongly opposes CMS’s proposal to query patients directly about their immigration status since this is likely to result in fewer undocumented aliens seeking treatment. It is well established that these types of inquiries will result in significant segments of the immigrant population not seeking care at all or in a timely manner. We support the comments of the National Association of Public Hospitals on this issue.

## **Payment Methodology**

The AAMC objects to the use of a retrospective payment methodology. The legislation clearly states that the payments may be made prospectively and adjusted retrospectively. The use of the word “may” in the legislation indicates that this is not the only methodology that can be used, but it strongly suggests that it is the one preferred by Congress. The AAMC supports the development of a prospective payment system that is designed to quickly and efficiently pay the funds to the providers who are meant to be helped by the availability of these funds. Reconciliation can be accomplished retrospectively.

## **Submission of Payment Request**

As was referenced earlier in our letter, CMS is requiring that providers submit claims within 90 days of the close of the federal fiscal quarter, or their claims will be denied. The latter requirement is supported by the statement that there is a “necessity for finality in the claims process.” However, as was discussed above, the legislation envisions a process that includes retrospective reconciliation and in no way suggests finality. CMS should provide a system that recognizes the need for flexibility in claims submission and does not impose unreasonable and overly rigid deadlines.

## **Covered Services**

The AAMC supports the comprehensive definition of “related hospital inpatient and outpatient services” that CMS uses in the proposal. We agree with CMS’ determination that extending coverage until “discharge” rather than “stability” will decrease the administrative complexity for hospitals in determining the patient’s condition. A broad definition will also provide the continuity of care that is in the best interest of the patient.

## **Unobligated State Allotments**

The proposal correctly quotes paragraph (a)(2) of section 1011 as saying that “funds appropriated under this section shall remain available until expended.” Despite the seemingly clear meaning of this phrase, the proposal states, “any unobligated state funds still remaining after the annual reconciliation process is complete for a given fiscal year will be returned to the U.S. Treasury.” The AAMC strongly opposes this proposal as thwarting Congressional intent that, without limitation, all of the appropriated funds be used to pay providers who treat undocumented aliens.

## **Appeals**

The proposal provides no opportunity for an appeals and grievance process, and no chance for a claim to be resubmitted and revised once it has been processed. The reasoning behind this approach is that the levels of payments are expected to be low.

The government typically expects the same rules to be followed by providers, regardless of the amount of reimbursement they are seeking. Low levels of reimbursement deserve to be treated with the protections given to larger payments. While Congress always expects a methodology to be implemented

that includes measures to combat fraud and abuse, CMS provides no means for providers to correct unjust errors. An appeal mechanism should be instituted, even if it is an abbreviated one. Likewise, it must be recognized that providers routinely attempt to submit accurate claims and must be given the chance to resubmit them when necessary.

If you would like to discuss these comments further, please contact Robert Dickler (rdickler@aamc.org) or Ivy Baer (ibaer@aamc.org) at 202-828-0490

Sincerely,

A handwritten signature in black ink, appearing to read "Jordan J. Cohen". The signature is fluid and cursive, with the first name "Jordan" being the most prominent.

Jordan J. Cohen, M.D.