DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

The purpose of this paper is to seek public comments concerning the policies and process that the Centers for Medicare & Medicaid Services (CMS) will use to make payments under section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Public Law 108-173, (December 8, 2003). This legislation is commonly referred to as the Medicare Modernization Act of 2003 (MMA).

This paper provides general information about section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, sets forth CMS' proposed implementation approach, provides information on the policy options under consideration, and establishes the general framework for submitting an enrollment application and payment requests.

While this paper solicits public comment on CMS' proposed implementation approach for section 1011 and increases the opportunity for public participation in the development of these policies, this paper neither establishes CMS' final implementation action nor establishes valid information collection. According to the Paperwork Reduction Act of 1995 (PRA), no persons are required to respond to collection of information unless it displays a valid Office of Management and Budget (OMB) control number.

CMS is soliciting public comments in advance of issuing a PRA package in order to refine our implementation strategy, minimize the amount of paperwork burden imposed on providers, and obtain public comments on our proposed implementation approach. Later this year, CMS will announce via a formal PRA notice our intention to establish or modify several information collection instruments.

Section 1011 does not delegate legislative rulemaking authority to the Secretary. We are not issuing a notice of proposed rulemaking or promulgating legislative rules. CMS will request public comment regarding our proposed implementation strategy via this document and implement this section of MMA by publishing a PRA notice in the Federal Register, an action that in any case is necessary for clearing the associated information collection instruments. In addition to finalizing the information collection instruments, the notice will provide general statements of policy, information regarding our implementation approach, and our interpretation of section 1011.

Given the statutory date for implementing this provision, we will use the emergency PRA notice and clearance process as outlined in the current PRA regulations, 5 CFR 1320.13. Under this process, the normal 60 and 30 day comment periods will be abbreviated to ensure that the

procedural requirements and associated policies are approved by OMB prior to the statutory implementation date of September 1, 2004.

Open Door Listening Sessions

On March 29, 2004, CMS held a special Open Door Forum (ODF) to obtain public input related to the implementation of this new provision and to allow interested parties to hear and be heard by other members of the healthcare industry.

CMS will also solicit input from the public on the issues discussed in CMS' section 1011 implementation strategy paper and on other items of interest surrounding the implementation of section 1011. The second ODF will be held on **August 2, 2004 at 2 p.m., (eastern time)**. The primary topic for consideration will be CMS' proposed implementation approach for section 1011 as outlined in this paper.

There are two ways to participate in the Special ODF--by phone or "in person."

1. To participate by phone: **Dial: 1-800-837-1935 & Reference Conference ID: 8498913**
Persons participating by phone are not required to RSVP.

Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880 and for Internet Relay services click here http://www.consumer.att.com/relay/which/index.html .
A Relay Communications Assistant will help you.

2. To participate "in person" at the CMS Baltimore Site, an RSVP is required.
To RSVP and register your comments please send them via email to SpecialODF@cms.hhs.gov by close of business, July 29, 2004. Please send us your name along with the name of your organization, and contact information (phone/fax/email). Please arrive no later than **1:30 p.m. (eastern time)** to allow time for parking and passing through security checkpoints. Photo identification is required at security points.

ADDRESS:
CMS Single Site Building
Multipurpose Room
7500 Security Boulevard
Baltimore, MD 21244
Directions: http://www.cms.hhs.gov/about/agency/visiting/

SUPPLEMENTAL INFORMATION:

We will consider comments on this paper if we receive them at the appropriate address, as provided below, no later than 5 p.m. on **Monday, August 16, 2004**. Comments received after this date, will not be considered.

Submitting Comments: We welcome comments from the public on all issues set forth in this paper to assist us in fully considering issues and developing policies. You can assist us by referencing the specific "issue identifier" that precedes the section on which you choose to comment.

Address: The public should address comments to Jim Bossenmeyer, CMS, Center for Medicare Management, Hospital and Ambulatory Group, Mail stop C5-01-14, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. E-mail comments should be submitted to section 1011@cms.hhs.gov.

Response to Comments: Because of the large number of comments that we expect on our proposed implementation approach, we are not able to acknowledge or respond to comments individually.

*For Further Information Contact***:** Jim Bossenmeyer, CMS, Center for Medicare Management, Hospital and Ambulatory Group, Mail stop C5-01-14, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. The telephone number is (410) 786-9317**.**

I. Background

Sections 1866(a)(1)(I), 1866(a)(1)(N), and 1867 of the Social Security Act (the Act) impose specific obligations on Medicare-participating hospitals that offer emergency services. These obligations concern individuals who come to a hospital emergency department and request examination or treatment for medical conditions, and apply to all of these individuals, regardless of whether or not they are beneficiaries of any program under the Act. Section 1867 of the Act sets forth requirements for medical screening examinations of medical conditions, as well as necessary stabilizing treatment or appropriate transfer. In addition, section 1867(h) of the Act specifically prohibits a delay in providing required screening or stabilization services in order to inquire about the individual's payment method or insurance status. Section 1867(d) of the Act provides for the imposition of civil monetary penalties on hospitals responsible for negligently violating a requirement of that section, through actions such as the following: (a) Negligently failing to appropriately screen an individual seeking medical care; (b) negligently failing to provide stabilizing treatment to an individual with an emergency medical condition; or (c) negligently transferring an individual in an inappropriate manner. (Section 1867(e)(4) of the Act defines "transfer" to include both transfers to other health care facilities and cases in which the individual is released from the care of the hospital without being moved to another health care facility.)

These provisions, taken together, are frequently referred to as the Emergency Medical Treatment and Labor Act (EMTALA), also known as the patient antidumping statute. EMTALA was passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Congress enacted these antidumping provisions in the Social Security Act because of its concern with an increasing number of reports that hospital emergency rooms were refusing to accept or treat individuals with emergency conditions if the individuals did not have insurance.

Section 1011 provides $250 million per year for fiscal years (FY) 2005-2008 for payments to eligible providers for emergency health services provided to undocumented aliens and other specified aliens. Two-thirds of the funds will be divided among all 50 states and the District of Columbia based on their relative percentages of undocumented aliens. One-third will be divided among the six states with the largest number of undocumented alien apprehensions.

From the respective state allotments, payments will be made directly to hospitals, certain physicians, and ambulance providers for some or all of the costs of providing emergency health care required under section 1867 and related hospital inpatient, outpatient and ambulance services to eligible individuals. Eligible providers may include an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization. A Medicare critical access hospital (CAH) is also a hospital under the statutory definition. Payments under section 1011 may only be made to the extent that care was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

Payments may be only for services furnished to certain individuals described in the statute as: 1) undocumented aliens; 2) aliens who have been paroled into the United States at a port of entry for the purpose of receiving eligible services; and 3) Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a "laser visa") issued in accordance with the requirements of regulations prescribed under a specific section of the Immigration and Nationality Act.

II. Policy Paper Organization

This paper outlines the payment methodology and the process we will use to make section 1011 payments. This paper describes and requests comments on the following:

Section	Description
III	Describes how state allocations will be determined
IV	Describes an eligible provider for purposes of section 1011
V	Describes an alien for the purposes section 1011
VI	Describes coverage services under consideration
VII	Describes the enrollment application process
VIII	Describes the reimbursement process from third-party payers and patients

Section	Description
IX	Describes how providers should identify and document the citizenship status of patients for the purposes of receiving payment under this section
X	Describes various payment methodologies under consideration
XI	Describes state funding pools under consideration
XII	Describes how a provider should submit a payment request
XIII	Describes how initial payment amounts will be determined (subject to the pro-rata reduction)
XIV	Describes quarterly provider payments options under consideration
XV	Describes the pro-rata reduction
XVI	Describes what happens to unobligated state allotments
XVII	Describes the appeals and grievance and claim adjustment processes
XVIII	Describes the reconciliation process
XIX	Describes the overpayment process
XX	Describes the compliance review process
XXI	Describes the information collection requirements

III. Determination of Annual State Allotments for FFY 2005 – FY 2008

[**If you choose to comment on issues in this section, please include the caption "Annual State Allotments" at the beginning of your comments.**]

As mentioned above, section 1011 provides $250 million per year for FY 2005-2008 for payments to eligible providers for certain emergency health services furnished to undocumented aliens.

Using the latest available data, this paper provides federal fiscal year (FFY) 2005 estimated state allotments that are available for distribution to eligible providers within each state and the District of Columbia that furnish emergency eligible services to eligible individuals. In addition, this paper provides the FFY state allotments that are available to the six States with the highest number of undocumented alien apprehensions for such fiscal year. This paper also describes the methodology used to determine each State's allotment.

Determination of State Allocation Based on Undocumented Aliens Percentage

The statute dictates that two-thirds of the total yearly appropriation, or $167 million, is to be proportionally divided among all 50 states and the District of Columbia. The amount of the state's allotment is to be based on the "the *percentage* of undocumented aliens residing in the State as compared to *the total number* of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census," (emphasis added) (MMA Section 1011(b)(1)(B)(ii)).

Because the statutory language requires the allocation calculation to be made by comparing a percentage to a national number, we would not be able to calculate the state allotments if the statutory provision is interpreted literally. In order to produce a mathematically meaningful result that would enable us to implement this subparagraph, and be consistent with the language of the committee report on section 1011, we have determined the "percentage" in section

1011(b)(1)(B)(ii) by comparing the number of undocumented aliens in the state as compared to the total of undocumented aliens in all states and the District of Columbia. Using information from the Department of Homeland Security (DHS) Office of Immigration Statistics, we have calculated the allotments for each state and the District of Columbia by multiplying the total appropriation ($167 million) by the proportion generated by dividing the number of undocumented aliens who reside in each state by the total number of undocumented aliens in all states (see attached chart). Because the statute bases the allocation of the $167 million on the proportion of undocumented aliens at one given time, these allocations will be the same for each state for each fiscal year (FY 2005-FY 2008).

As of January 2003, DHS estimated that each of the following four states had fewer than 1,000 undocumented aliens residing in the state: Maine, Montana, North Dakota, and Vermont. From discussions with DHS, we did not believe it was appropriate to assume that there were zero undocumented aliens residing within these states simply because DHS estimates are rounded to the thousand. Thus, for purposes of implementing Section 1011, we have assumed that 500 undocumented aliens reside in each of these four states.

Allocation Based on Undocumented Alien Apprehensions (Distributing $83 million)

The remaining one-third of the total appropriation, or $83 million, is divided among the six states with the highest number of undocumented alien apprehensions for each fiscal year. The statute requires that the data to be used for determining the "highest number of undocumented aliens apprehensions for a fiscal year shall be based on the apprehensions for the 4-consecutive-quarters ending before the beginning of the fiscal year for which information is available for undocumented aliens in such states, as reported by the Department of Homeland Security." Section 1011 (b)(2)(C) requires that we use data from the four consecutive quarters ending before the beginning of the fiscal year, we propose to identify the six states based on data available prior to the fiscal year when the funding is available. The last available four fiscal quarters ending before the beginning of FFY 2005 (which begins October 1, 2004) would be from July 1, 2003 through June 30, 2004. Thus, we will identify the six states to receive portions of the $83 million based on the highest number of undocumented alien apprehensions for the time period from July 1, 2003 to June 30, 2004.

Our preliminary analysis, using apprehension data from DHS for FY 2003, indicates that the six states with the highest number of undocumented alien apprehensions were Arizona, California, Florida, New Mexico, New York, and Texas. It is possible that these states could change when final apprehension data from July 1, 2003- June 30, 2004 is collected and analyzed. We expect to make this information available before the start of the program.

Once the six states have been identified, the statute directs us to allocate money to those states in the following manner:

Determination of Allotments

The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented alien apprehensions in the State in that fiscal year as compared to the total of such apprehensions for all such States for the preceding fiscal year.

Again, the mathematical formula in statutory language is problematic. Therefore, we have determined a calculation for the statutory usage of "percentage" by comparing the number of alien apprehensions in the state as compared to the total number of alien apprehensions in all states and the District of Columbia. Moreover, the statute directs us to determine the percentage based on the number of alien apprehensions in the *current* year as compared to the total number of apprehensions in the *previous* fiscal year. Taking a literal interpretation of the statute would be problematic in that if the total number of apprehensions in the current year were to increase, then the six states' proportion of the previous year's total would exceed 100 percent of the money available.

For example, assume that in 2004 (previous FY) State A had 10 apprehensions, and State B had 30 apprehensions- for a total of 40 apprehensions in the previous fiscal year. In FY 2005, State A might have 20 apprehensions and State B might have 30 apprehensions, for a total of 50 apprehensions in the current fiscal year. If we followed the exact statutory language, State A would receive 50 percent of the allocation (20 apprehensions in current FY/40 total apprehensions in previous fiscal year), and State B would receive 75 percent (30/40). Using these proportions would result in allocating 125 percent of the $83 million specified in law, a result that would be legally prohibited. Alternatively, if the total number of apprehensions in the current year were to decrease, then the six states' proportion of the previous year's total could be less than 100 percent of the available funds, again making it impossible to allocate the funds as provided for by the statute.

Additionally, a literal interpretation of the statute would delay implementation inappropriately in that it would require us to wait for data on the number of undocumented alien apprehensions to be made available for the current year. With the inherent time lag necessary for DHS to collect and compile the data, FY 2005 data would not be available until November 2005. Not knowing final allotments until after the end of the fiscal year could impose a burden on providers if payments had to be reconciled after the end of the year.

Given the ambiguity in the statutory language, we propose that the *current* year used to identify the six states with the highest number of undocumented alien apprehensions is actually a time prior to the start of the current fiscal year. We believe it was the legislative intent to calculate the state proportions based on apprehension data from the same time period that is prior to the start of the current fiscal year. Thus, in consideration of the need for symmetry between the numerator and the denominator, we plan to use the same time period that is used for identifying the six states as for determining the proportions (July 1, 2003- June 30, 2004 for FY 2005). Thus, we plan to determine the FY 2005 allotments to the six states based on the proportion of undocumented alien apprehensions in a given state for the period of July 1, 2003- June 30, 2004, compared to the total of such apprehensions for all six states for the period of July 1, 2003- June 30, 2004.

For purposes of determining the allocation for the six states in subsequent FYs , we will use the period of July 1-June 30 of the previous year (i.e., FY 2006 will be based on the number of apprehensions for July 1, 2004-June 30, 2005.)

Preliminary State Allocations

Attachment A identifies preliminary estimates of state allocations. The state specific allocation of the $167 million is based on already available data required to calculate the funding amounts. These state allocations will be the same for each fiscal year (FY 2005-FY 2008). The six state allocations of the $83 million is only a preliminary estimate and gives providers in the six states an idea of the order of magnitude of the size of the total state allocation. Final FY 2005 allotments for the six states will be determined before the implementation of the program. Updated allotments for the $83 million for FY 2006-2008 will be determined before the start of each fiscal year.

IV. Eligible Providers

[**If you choose to comment on issues in this section, please include the caption "Eligible Providers" at the beginning of your comments.**]

For the purposes of this provision, a hospital, physician, or provider of ambulance services (including an Indian Health Service (IHS) facility whether operated by the IHS or by an Indian tribal or tribal organization) is considered an eligible provider. "Hospital" is defined at section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) and generally include all Medicare participating hospitals, except that such term shall include a critical access hospital (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(r)). While the definition of hospital under § 1011(e)(3) cross-refers to § 1861(e) of the Social Security Act, and does not expressly limit coverage to hospitals with a Medicare participation agreement under § 1866, "eligible services" are defined in § 1011(e)(2) as meaning, in pertinent part, "health care services *required* by the application of section 1867 of the Social Security Act . . ." Because section 1867 establishes legal obligations only for hospitals participating in the Medicare program, therefore, only Medicare participating hospitals can furnish "services required" by section 1867. Thus, only Medicare participating hospitals can apply to receive funds under section 1011.

"Physician" is defined at section 1861(r) of the Act (42 U.S.C. 1395x(r) and include doctor of medicine (MD), doctor of osteopathy, doctor of optometry, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, chiropractors, or doctors of dental surgery.

While section 1011 does not define a "provider of ambulance services," we propose to pay a state licensed "provider of ambulance services" for covered emergency transportation services to a hospital emergency department or from one are hospital to another.

"Indian Tribe" or "Tribal organization" are described in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

V. Alien

[**If you choose to comment on issues in this section, please include the caption "Alien" at the beginning of your comments.**]

As specified in (c)(5) of section 1011of the MMA, aliens are defined as:

- Undocumented Aliens; or

- Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services; or

- Mexican citizens permitted to enter the United States for not more than 72 hours under the authority of a biometric machine readable border crossing identification card (also referred to as a "laser visa") issued in accordance with the requirements of regulations prescribed under section 101(a)(6) of the Immigration and Nationality Act (8 U.S.C. 1011(a)(6)).

VI. Covered Services

[**If you choose to comment on issues in this section, please include the caption "Covered Services" at the beginning of your comments.**]

Paragraph (c)(1) of section 1011 requires the Secretary to make payments, from the allotments described earlier in that provision, for eligible services to undocumented aliens. "Eligible services" are defined in paragraph (e)(2) as "health care services required by the application of section 1867 [EMTALA]. . .and related hospital inpatient and outpatient services and ambulance services (as defined by the Secretary)." For hospital and ambulance services, the authority to pay for "related" services, as well as for those the hospital is required to provide under EMTALA, is clear. For physician services, we believe that the statutory language also could be read to provide for payment for "related" physician services.

Under the Medicare Act, inpatient hospital services are paid under Part A while the associated physician services are paid under part B. Thus, normally EMTALA services give rise to separate claims under part A and part B. Section 1011, however, is not codified in the Medicare Act and, therefore, we are not required to follow those billing conventions. Moreover, Congress seems to have intended to permit simultaneous payment for both hospital and physician services furnished at the same time by giving the hospital the option to elect to receive payment for the associated physician services, see section 1011(c)(3)(C)(i). Since section 1011 includes payment for both related inpatient and outpatient services, we believe that in the context of this new program the statute can reasonably interpreted to include the associated physician services at the hospital that are related to EMTALA.

For hospital services, payment would be made for covered services, which would begin when the hospital's EMTALA obligation begins, typically this is, when the individual arrives at the hospital emergency department and requests examination or treatment for a medical condition or if the individual comes to an area of the hospital other than the dedicated emergency department for an emergency medical condition. For specialty hospitals receiving appropriate transfers under

EMTALA (section 1867(g) of the Act), coverage could begin when the individual arrives at the specialty hospital.

For physician services, we propose to cover all medically necessary and appropriate services which physicians furnish to a hospital inpatient or outpatient patients who receive emergency services required by section 1867 (EMTALA) or "related' inpatient or outpatient services. Our reasons for planning to adopt that coverage option for hospital services are explained further below. As noted above, the definition of "physician" that we are required by section 1011 to use is the section 1861(r) definition, which includes certain practitioners other than MDs and doctors of osteopathy, such as dentists and chiropractors. Medically necessary and appropriate physician services would be determined under local medical practice standards.

Follow-up care provided by a physician to an individual who is no longer receiving hospital services covered under this section would not be covered. Non-coverage of physician services would extend to services, which might be furnished when the patient is neither a hospital inpatient nor outpatient, even if the services are needed to treat the same illness, or injury that caused the EMTALA provision to apply. For example, if an individual were treated as an outpatient in a hospital emergency department for a severe cut and required minor surgery to close the wound, thus, stabilizing his or her medical condition, both the hospital and physician services in that setting would be covered. However, subsequent physician office visits provided after stabilization would not be covered, even if the visits were for the purpose of removing stitches or providing other post-surgical care for the injury that caused the original emergency department visit.

For ambulance services, we would consider all medically necessary ambulance transportation of a patient to the first hospital at which he or she is seen for an emergency medical condition. In addition, we will cover any medically necessary ambulance transportation of an unstable EMTALA patient from the first hospital to another hospital for EMTALA-required care at the second hospital eligible for reimbursement. Although ambulance providers are not themselves subject to EMTALA under section 1867, such transport services, when medically necessary, are "related" to services that a hospital is mandated under EMTALA to provide.

Proposed Approach

We are proposing that coverage ends under section 1011 when a patient is discharged from the hospital. We believe that this approach would be the least burdensome for hospitals, since no splitting of costs/charges or other information would be needed to determine payments during a stay. This would enable us to consider all costs incurred by the hospitals for treatment of undocumented aliens during each stay eligible for reimbursement.

Patient discharge is a clearly documented event in the medical record and it would not require any additional finding of "stability" beyond the attending physician's decision to discharge. This option would be simpler for the hospital since it does not require separate assessment of costs for an inpatient's covered and non-covered parts of a single day, or other additional information to determine payment. By providing the most comprehensive definition of "related", it will effectively capture all costs of care a hospital has to render as a result of having admitted an undocumented alien under EMTALA. This approach also would result in payments to hospitals for expensive procedures that may be provided in the same stay but are not themselves required

to deal with the emergency for which the patient was admitted. Given this likelihood, we welcome comments regarding this interpretation of the statute.

Other Options Considered

We considered two other options for establishing when coverage under section 1011 ends and are interested in receiving public comment on the desirability and operational feasibility of these options.

We considered an approach by which coverage for the hospital that first treats the individual until the individual is stabilized, notwithstanding any inpatient admission. (In connection with this option, we note that under current EMTALA regulations, the obligation of the hospital which first treats the individual ends when the individual is either stabilized, appropriately transferred to another facility, or admitted in good faith as an inpatient for stabilizing treatment.). For a specialty hospital receiving an appropriate transfer, coverage also would continue until the individual is stabilized. For an inpatient of either hospital, this would necessitate a stabilization determination in the middle of the patient's stay, and charges/costs or other information (such as diagnostic or procedural information) needed to determine payments would have to be divided between both portions of the entire stay, to assure that the bill submitted for section 1011 includes only covered services.

While we considered this option, we do not now favor this approach since it would necessitate a stabilization determination in the middle of the patient's stay. This approach appears to impose additional administrative burdens on hospitals.

We note that some have suggested that we consider an approach under which coverage for the hospital, which first treats the individual, would end when that hospital admits an unstable individual for inpatient treatment. We recognize that such an approach would allow us to identify and pay for the services required by EMTALA, and would help hospitals and other providers clearly identify the point at which coverage terminates. However, this option would not fully implement the statute since it would not provide payment for EMTALA-related services, as required under section (e)(2) of section 1011. Therefore, we do not believe this approach can be adopted.

We also considered limiting "related services" by the hospital to services furnished within a specific time frame after stabilization or inpatient admission. For example, coverage of outpatient hospital services at the hospital to which the patient initially presents could be limited to services that are furnished on the date on which the patient is stabilized, and inpatient services coverage could be limited to services furnished on the calendar day immediately following the date of a good faith admission to stabilize the patient's emergency medical condition, or on the next calendar day. Coverage of inpatient and outpatient hospital services of specialty hospitals could be limited to services furnished on the calendar day immediately following the date of admission as a result of an appropriate transfer required by EMTALA, or on the following calendar day. This option would necessitate submission of separate costs/charges or other information (such as diagnostic or procedural information) needed to determine payments for the first part (that is, the covered part) of the patient's stay.

Since this option would limit coverage to a defined period of time after admission, it would reduce payments to hospitals under section 1011 in those situations in which a few individuals with a serious illness or disease utilize a disproportionate amount of services. We recognize that some may argue that not all "EMTALA-related services" would necessarily be furnished within a specified time after admission, we have not received any data that conclusively demonstrates the "right" time period for all cases. Moreover, we do believe it is likely that, in general, the most intensive procedures or services required for an emergency patient would be those furnished during the earliest part of a stay. This option thus provides a clear objective test that may be easy for hospital staff to understand and implement. In addition, we believe this approach may be more consistent with hospital billing systems than the stabilization option discussed above.

VII. Submission of an Enrollment Application

[**If you choose to comment on issues in this section, please include the caption "Enrollment Application" at the beginning of your comments.**]

Section 1011(c)(3)(C) of the MMA states that the Secretary shall provide for the election by a hospital to either receive payments to the hospital for –

(i) hospital and physician services; or

(ii) hospital services and a portion of the on-call payments made by the hospital to physicians.

To implement this provision of the statute, 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.

Enrollment Process and Application for Medicare Participating Providers

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 one-time enrollment application to participate in the section 1011 program. A hospital, physician, or provider of ambulance services, including those operated by the Indian Health Service and Indian tribes and tribal organizations, already enrolled in the Medicare program will be allowed to submit an abbreviated enrollment application. Further, as stated above in section IV of this paper, because section 1867 establishes legal obligations only for hospitals participating in the Medicare program, therefore, only Medicare participating hospitals can furnish "services required" by section 1867, we are proposing that only Medicare participating hospitals can apply to receive funds under section 1011.

While completing the enrollment application increases the paperwork burden for some providers, we believe that this process is essential to issuing electronic payments to providers and ensuring payments are made only to qualified providers. Moreover, this application will be a measure to

ensure that inappropriate or fraudulent payments are not made as required by section 1011(d)(1)(B). Specifically, this application would:

- Allow CMS' designated contractor to verify that the hospital, physician or provider of ambulance services is currently enrolled as a Medicare provider;
- Allow hospitals to make a payment election, as required by section 1011(c)(3)(C);
- Requires hospitals to notify physicians that it employs or maintains a contract upon its election to receive both hospital and physician payments; (THESE ARE COLLECTION REQUIREMENTS THAT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE)
- Requires hospitals electing hospital and physician payments to provide reimbursement to physicians in a prompt manner;
- Prohibits hospitals electing to receive both hospital and physician payments from charging an administrative or other fee to physicians for the purpose of transferring reimbursement to physicians (see section 1011(c)(3)(D));
- Allows CMS' designated contractor to obtain necessary financial information to effectuate payments and issue the appropriate tax information; (THESE ARE COLLECTION REQUIREMENTS THAT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE)
- Establish the state of service for each provider. This will assist CMS or its designated contractor in making provider payments from the appropriate state allocation;
- Establishes the provider's obligation to repay any assessed overpayment within 30 days of notification by CMS or its designated contractor; and,
- Informs a provider that applicable Federal laws apply to submission of false claims.

Finally, we propose that the enrollment application would be submitted electronically via a secure website established by our designated contractor and that an original copy of the enrollment application be submitted to CMS' designated contractor for verification purposes (THESE ARE COLLECTION REQUIREMENTS THAT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE.)

To ensure that the public has an opportunity to comment on the information collection instrument we have designed, we will seek additional public comment via the PRA process later this year, but interested persons are invited to send comments regarding public burden, related policies, or any other aspect of this collection of information.

Submission of Enrollment Application for Medicare Participating Providers

Applications by participating Medicare providers must be submitted within 30 days of the close of a Federal fiscal quarter (i.e., January, April, July, and October) in order to be eligible to receive reimbursement for the prior 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.

Enrollment Process and Application for Non-Medicare Participating Providers

We propose that a physician or provider of ambulance services not currently enrolled in the Medicare program request and submit a completed Medicare enrollment application (i.e., a

CMS-855I or CMS-855R for physicians or a CMS-855B of a provider of ambulance services) and the abbreviated application (see attached) to CMS' designated contractor. The designated contractor will review and approve each section 1011 enrollment request application. **Note**: A physician or provider of ambulance services need not enroll in the Medicare program in order to receive section 1011 reimbursement. However, we will use the Medicare enrollment application and the abbreviated enrollment application to ensure that inappropriate, excessive or fraudulent payments are not made from state allotments.

The purpose of collecting this information is to determine or verify the eligibility of individuals and organizations to participate in the section 1011 program. This information will also be used to ensure that no payments are made to a physician or provider of ambulance services who is excluded from participating in Federal or State health care program.

Submission of Enrollment Application for Non-Medicare Participating Providers

Enrollment applications from non-Medicare participating providers must be approved prior to services being claimed for section 1011 reimbursement. If a non-Medicare provider renders an eligible service to an eligible alien before his or her section 1011 enrollment application is approved, the provider would be ineligible for section 1011 reimbursement.

Change in Banking and Financial Information

To ensure that payments are issued in a timely manner and in an effort to reduce the administrative burden both for provider submitting reimbursement requests and for CMS, we are proposing that each approved enrollee notify CMS' designated contractor in writing regarding any change in its bank routing or financial information 15 days before the end of the Federal fiscal quarter. We believe that this approach will ensure the efficient and effective administration of the statute.

VIII. Reimbursement from Third-Party Payers and Patients

[**If you choose to comment on issues in this section, please include the caption "Third-Party Reimbursement" at the beginning of your comments.**]

Paragraph (c)(1) of section 1011 requires the Secretary to directly pay providers for the provision of eligible services to aliens to the extent that the eligible provider was not otherwise reimbursed (through insurance or otherwise) for such services during that fiscal year.

Accordingly, we propose that each provider seek reimbursement from all available funding sources, including, if applicable, Federal (e.g., Medicare), State or local government (e.g., Medicaid), third-party payers (e.g., private insurers or health maintenance organizations), or direct payments from a patient, prior to requesting reimbursement under section 1011. We believe that this is consistent with the statutory intent of this provision and will limit reimbursement to only those instances where no other reimbursement is likely to be received.

Impact of Payments from Third-Party Payers

CMS proposes that providers not request section 1011 reimbursement where payment had already been made or could reasonably be expected to be made by a Federal, State or local government plan or where third-party reimbursement such as workers' compensation, liability insurance, no-fault insurance or an employer group health plan will provide reimbursement for eligible services. In addition, since a limiting charge does not apply to these payments, CMS proposes that a provider be allowed to "balance bill" in the aforementioned situations for claims that are not fully paid by another insurer.

Further, in the event that a provider receives third-party reimbursement, including Medicaid, subsequent to a section 1011 payment, CMS proposes that the provider must reimburse the section 1011 payment within 30 days of receipt of such third-party reimbursement to CMS' designated contractor.

Use of Existing Practices and Procedures to Identify Reimbursement Sources

We propose 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.

Impact of Payments from a Patient

To the extent that an eligible individual self-pays for his or her care, CMS proposes that the provider reduce its reimbursement request by the amount paid by the eligible individual. In addition, since a limiting charge does not apply to these payments, CMS proposes that a provider be allowed to "balance bill" in the aforementioned situations for claims that are not fully paid by another insurer or the patient.

Receipt of Third-Party or Patient Payments after Section 1011 Reimbursement is Received

We propose that if a hospital or other provider receives a payment from a third-party payer or a patient for emergency services provided to an alien described in (c)(5) after a section 1011 payment request has been filed by the provider, that the provider notify the CMS' designated contractor immediately. In these situations, a provider may be assessed an overpayment if a section 1011 payment had been issued.

Impact of Grants and Gifts

We propose that grants and gifts to hospitals not be considered by the hospital when making a claim for section 1011 reimbursement.

IX. Documentation of Citizenship Status

[**If you choose to comment on issues in this section, please include the caption "Documentation" at the beginning of your comments.**]

Section 1867 of the Social Security Act (EMTALA) requires a hospital that provides emergency services to medically screen all persons who come to the hospital seeking emergency care to determine whether an emergency medical condition exists. If the hospital determines that a

person has an emergency medical condition, the hospital must provide treatment necessary to stabilize that person or arrange for an appropriate transfer to another facility.

Section 1867 precludes a participating hospital from inquiring about an individual's method of payment or insurance status before a medical screening examination. For purposes of payment under Section 1011, hospitals and other providers are required to collect and maintain additional information regarding the immigration status of patients.

After a hospital initiates the medical screening for an emergency medical condition and stabilization efforts have been initiated, hospital staff routinely begins a financial screening process to determine how an individual will pay for his or her health care. In many cases, the financial liability associated with an individual's care is borne by a third-party payer, including Medicare, Medicaid, or private insurance. In some cases, a patient is neither insured nor financially able to pay for his or her care. If an individual is not enrolled in Medicaid when a hospital provides emergency medical services and the patient has no other insurance and is unable to pay treatment, many hospitals will attempt to enroll the patient in Medicaid.

An applicant for Medicaid must declare by signing a declaration whether he or she is a citizen or national of the United States or an alien in a satisfactory immigration status. All Medicaid applications include a question similar to, "Are you a U.S. Citizen?" This question is designed to establish Medicaid eligibility. Qualified aliens applying for Medicaid, for example refugees and permanent resident aliens, must provide documentation of satisfactory immigration status in addition to signing a declaration they are in a satisfactory immigration status. Undocumented aliens and other aliens who are eligible for "emergency-only" Medicaid are not required to provide documentation of immigration status or sign a declaration of immigration status. In fact, Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et. seq., 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. Thus, in operating or participating in a federally assisted program, a provider should not, on the basis of race, color or national origin, directly or indirectly differentiate among persons in the types of program services, aids or benefits it provides or the manner in which it provides them. For example, providers should treat all similarly situated individuals in the same manner, and should not single out individuals who look or sound foreign for closer scrutiny or require them to provide additional documentation of citizenship or immigration status.

In May 2004, the General Accounting Office (GAO) issued a report titled, "Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Care Costs." In this report (GAO-04-472), the GAO attempted to examine the relationship between uncompensated care and undocumented aliens by surveying hospitals, but because of a low response rate to key survey questions and challenges in estimating the proportion of hospital care provided to undocumented aliens, GAO could not determine the effect of undocumented aliens on hospitals' uncompensated care costs.

The GAO also found that, "Determining the number of undocumented aliens treated at a hospital is challenging because hospitals generally do not collect information on patients' immigration status and because undocumented aliens are reluctant to identify themselves." Further, the GAO concludes that, "The lack of reliable data on this patient population and the lack of proven methods to estimate their numbers make it difficult to determine the extent to which hospitals

treat undocumented aliens and the costs of their care." Finally, the GAO recommended that, "the Secretary develop reporting criteria for providers to use in claiming these funds and periodically test the validity of the data supporting the claims."

In considering how providers will identify and document the citizenship status of patients for the purposes of receiving payment under this section, CMS believes 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 aliens from seeking necessary treatment.

Proposed Approach

We are proposing to adopt a patient based documentation approach. Using this approach, providers would request information about a patient's citizenship or immigration status prior to discharge, but after the patient is identified as self-pay and not Medicaid eligible. Note: Under EMTALA, a participating hospital may not delay a medical screening examination or treatment in order to inquire about the individual's method of payment or insurance status. We also would not allow a delay in the medical screening examination because of inquiries about citizenship. While remaining consistent with EMTALA regulations, under this statute, the provider will be required to document the patient's file regarding the patient's citizenship status and whether the patient is a member of a group for which payment under section 1011 is possible. In documenting citizenship status, a provider may use a Medicaid enrollment application or another existing information collection instrument. Since states require Medicaid applicants to state whether they are a U.S. citizen, providers may be able to utilize an existing process to determine whether the patient is an alien as described in section 1011. As an alternative to using the Medicaid enrollment application process or another established information collection instrument, a provider could use the information collection instrument that we have designed (see attached) to obtain the necessary information regarding a patient's citizenship. In the event that a state's Medicaid enrollment application or another existing information collection instrument does not provide the level of detail that we have included in the newly designed information collection instrument, we would ask providers to supplement their existing collection instrument to include any additional information requested in the proposed collection instrument.

We would also ask providers to make a good faith effort to obtain citizenship information. Since section 1011 funds are limited and the purpose of requiring hospitals to obtain information on citizenship or immigration status is to ensure that those funds are used for the purposes authorized by the statue, we would ask providers to attest to the fact that information contained in the screening collection is correct to the best of their knowledge and abilities. Individual-level citizenship or immigration information would be maintained at the hospital level and not submitted routinely to CMS. While some individuals have suggested that citizenship information be sent to the CMS, we do not believe that collecting this information is necessary given the payment methodology we are proposing to adopt. In addition, we are concerned about the paperwork burden and administrative expense associated with sending citizenship data to CMS on a regular basis. In lieu of receiving this information routinely, CMS' designated contractor can review and determine the aggregated number of claims filed and the percentage of patients qualifying as an alien as described in paragraph (c)(5) of section 1011.

Moreover, we believe that documentation requirements described in this approach will further our efforts to ensure that we reimburse providers only for the care associated with aliens described in paragraph (c)(5). In selecting this approach, we concur with the GAO's conclusion in GAO-04-072 that, "Until reliable information is available on undocumented aliens and the costs of their care, accurate assessment of their financial effect on hospitals will remain elusive, as will the ability to assess the extent to which federal funding offsets their costs."

In adopting this approach, we do not believe that we are imposing costly or burdensome documentation requirements, which could inappropriately discourage persons from seeking needed emergency medical services. While we would not require that providers use the proposed information collection that is shown in Attachment B, we would require that providers collect and maintain the same information contained in the proposed information collection instrument. This can be accomplished in a number of ways – a provider may collect and maintain any additional information needed to support a citizenship decision by supplementing their existing collection instruments or a provider may use the proposed information collection instrument as the basis of its citizenship decision. In either case, a provider must collect and maintain all of the information contained in the proposed information collection.

While this approach may increase the paperwork burden for some providers, we believe that this increase is minimal and that much of the information can be gathered from existing Medicaid enrollment or other existing financial screening processes. As noted above, under this proposal, while hospitals and other providers will be required to collect information regarding individuals' citizenship status in order to assure that section 1011 funds are being spent appropriately, we do not propose that this information be submitted to CMS as part of routine claims processing. The provider would maintain this information unless required for purposes of audit or program integrity review. Moreover, since hospitals are in the best position to request information regarding a patient's citizenship status after meeting EMTALA requirements, we would require that hospitals maintain citizenship information for patients for whom section 1011 reimbursement would be sought and that hospitals would make this information available to physicians and ambulance providers. Thus, the hospital determination of citizenship would also apply to "related" ambulance and physician services as well.

Other Options Considered

We considered two other documentation options and are interested in receiving public comment on the types of information already collected during the Medicaid enrollment process and are asking for suggestions to minimize the paperwork burden in documenting citizenship status for the purposes of documenting section 1011 payments.

We considered allowing hospitals to make a determination of alien status. During the Open Door Listening Session held on March 29, 2004, several participants suggested that CMS not require the hospital to ask whether a patient was a U.S. Citizen. Information already collected by hospitals during the financial screening process would be used to make a reasonable assumption that the patient is an undocumented alien. This could include a combination of factors including statement of a foreign address or place of birth with a missing or invalid social security number or a lack of insurance, including Medicaid. Providers would make a good faith effort to obtain correct information and attest to the fact the information was correct to the best of their knowledge and belief.

We also considered establishing a hospital's alien patient workload by taking the ratio of number of emergency Medicaid eligible patients to the number of full-scope of Medicaid eligible patients served by a provider and apply that ratio to the provider's overall uncompensated care costs.

While we also considered the two options discussed above, we do not favor either of these approaches because these options do not adequately document the citizenship status of aliens described in paragraph (c)(5) of section 1011. In the case of establishing a statistically based determination, we do not believe the data would yield a valid proxy for the services provided to aliens defined in (c)(5).

X. Payment Methodology

[**If you choose to comment on issues in this section, please include the caption "Payment Methodology" at the beginning of your comments.**]

Paragraph (c)(4) requires that we make payments to eligible providers for the costs incurred in providing eligible services to aliens as described in (c)(5). In this section, we describe how we intend to reimburse eligible providers for providing emergency services to undocumented aliens and certain other aliens.

Section 1011 establishes a broad framework governing payment for the eligible services furnished to eligible individuals. All payments must be taken from a particular state's allotment, thus, there is a finite amount of money that can be paid in any particular state or the District of Columbia for a fiscal year. In addition, the amount paid to a provider cannot exceed the costs incurred (§ 1011(c)(2)(A)(i)), but the payment could be less than the provider's costs based on a methodology established by the Secretary, see section 1011(c)(2)(A)(ii). In addition, section (d)(1) provides that the Secretary establish measures to ensure that inappropriate, excessive or fraudulent payments are not made. The statute also requires the Secretary to make a pro-rata reduction of previous payments if the amount of funds allocated to a State is "insufficient to ensure that each eligible provider receives the amount that is calculated under [§ 1011(c)(2)(A)]." Thus, each "eligible provider" would receive some payment for furnishing "eligible services" but the precise amount of the final payment is uncertain. Moreover, the amount of the interim payment may vary by service, the number of eligible providers, the type of eligible provider, the location of the provider, or where the service is furnished. The Secretary is required to make quarterly payments under § 1011(c)(3)(D).

Within this broad framework, the statute gives the Secretary discretion to determine a payment methodology (§ 1011(c)(2)(A)(ii)) and contained specific provisions that would permit the Secretary to make payments on the basis of advance estimates of expenditures with subsequent adjustments for any overpayments or underpayments. Section 1011(d)(2). The statute also requires the Secretary to adopt measures that will prevent inappropriate, excessive, or fraudulent payments. Section 1011(d)(1)(B)

While this system would allow CMS to design a prospective payment system for section 1011, we are not recommending this approach. We have no provider specific data that we can use to estimate the cost of services currently provided to eligible aliens. Accordingly, we are proposing

that CMS make retrospective payments at this time. We believe that this is the only practical methodology that we can adopt that would ensure that interim payments would not exceed the available state allotment and that we would not need to make significant adjustments to those payments. In the future, if we determine that prospective payments can be made effectively and with a minimum number of overpayments, we will consider revising our proposed payment methodology.

Given that CMS is proposing to establish a retrospective payment methodology, another issue that must be resolved to implement section 1011 is the question of what type of retrospective payment methodology CMS should use in reimbursing providers for care provided to undocumented aliens.

Proposed Payment Methodology:

We are proposing to adopt a bill-specific payment methodology. CMS would require providers to submit bills or claims for payment on a service-by-service or per discharge basis, much as they currently do under Medicare and other insurance programs. Payment would be determined based on the information included in these claims. Specifically, we propose that Medicare payment rules be used to calculate the payment amount for hospital, physician, and ambulance services under section (c)(2)(ii). Indian Health Service facilities and Tribal organizations would also be required to submit valid claim submissions and the payment amount under section (c)(2)(ii) would be paid based on current Medicare payment rules.

This approach would establish a fair and consistent approach to provider reimbursement for the costs each provider incurs for treating undocumented aliens. All payment requests would be aggregated (by CMS during claims processing) at the state level. Each provider within a state would receive a payment equal to the Medicare reimbursement rate or, if provider payments exceed the state allotment, providers would receive a proportional payment of the Medicare reimbursement rate. Thus, if a pro-rata reduction were applicable, then CMS would apply a common discounting factor in order to adjust provider payments to the state allocation amount. We believe this method is the most accurate method for determining payments based on the actual services provided to undocumented aliens.

Using this approach, CMS would be able to gather specific information about the types of services provided to undocumented aliens. Furthermore, the level of detail about services that is available through a claim-by-claim service-based payment approach will help CMS to ensure that inappropriate, excessive or fraudulent payments are not made. For example, this information could assist in identifying services for which section 1011 payment should not be made where a State or other payer made payment for them. We are particularly concerned that section 1011 funds do not duplicate payment made by other sources and we will specifically request comments on how we can ensure that duplicate payments are avoided.

Other Options Considered

While we also considered three other options, we do not favor these approaches. However, we are interested in public comment on the desirability and operational feasibility of these options.

We considered establishing a service-based payment methodology with aggregate quarterly summaries. This option is similar to our proposed approach, except that CMS would require each provider to submit one aggregate quarterly report of all of its charges for all covered section 1011 services. Payment would be determined based on the information included in these quarterly summaries. Unlike the bill specific option mentioned above, this approach would not require providers to submit individual bills or claims for payment on a service-by-service basis, as they currently do under Medicare. Providers would be required to maintain documentation sufficient to allow information from the quarterly report to be traced back to the individual patient services, thus permitting an audit of their claims.

However, we do not believe that this approach would provide the level of detail about services that is available through a claim-by-claim service-based payment approach. In addition, this approach limits CMS' ability to ensure that inappropriate, excessive or fraudulent payments are not made. Finally, this approach would still require that providers maintain claim-specific payment information (i.e., service-by-service or stay-by-stay) for each service provided, although it would not be submitted to CMS.

We also considered establishing a payment methodology that utilized broad payment categories. Several interested parties have suggested that CMS establish five or six broad payment categories, such as:

- Ambulance Service
- Physician Only Emergency Department Service
- Emergency Department – Visit Only (hospital and a portion of on-call payments)
- Emergency Department -- Visit Only (hospital and physician services)
- Emergency Department with Inpatient Admission
- Emergency Department with Inpatient Admission and subsequent Surgery

While this approach would simplify payment methodology for CMS, we believe that establishing a payment methodology consisting of broad payment categories would require burdensome and costly billing system modifications for most providers. In addition, this approach does not allow a provider to be paid based on the costs incurred for each specific service. Since this approach would utilize an average payment amount for a particular service category (e.g., ambulance service), it would result in overpaying some providers for particular services.

Finally, we considered establishing a payment methodology based on a proxy. To simplify the payment process and minimize documentation requirements, several interested parties have suggested that CMS establish a proxy methodology (such as determining hospital payments for undocumented alien services based on total ER visits, or on a percentage of Medicaid payments the hospital receives.) While this approach would allow CMS to distribute payments prospectively, it does not allow a provider to demonstrate the actual cost incurred for rendering EMTALA-related services, does not link payment to a specific patient, and may overstate the amount of payments to hospitals.

While we believe that a proxy payment methodology represents an alternative to individual or aggregate claim submissions, we do not believe that a proxy methodology can be validated on a claim specific basis. In addition, CMS could only validate the proxy measures, not the actual

services provided. In general, we believe that any proxy measure will benefit some providers while disadvantaging other providers. Specifically, we believe that a proxy measure would benefit large hospital systems with complex computer systems and disadvantage smaller hospitals, rural hospitals, and Indian Health Service facilities that may be unable to provide the necessary information to receive information from a single proxy methodology.

Finally, we are unable to establish a proxy measure that would provide fair payments to physicians and ambulance providers. We believe that physicians and ambulance providers would be disadvantaged if we adopted this type of payment methodology.

XI. Creation of State Funding Pools: Distribution of Payments among Provider Types

[**If you choose to comment on issues in this section, please include the caption "State Funding Pools" at the beginning of your comments.**]

As we have stated above, state allotments will be based on the statutory formula. Once the state allotments are determined, we need to determine whether CMS should establish a single allotment per state or create distinct provider allotments per state. We considered the following funding distribution options:

Proposed Approach

CMS is proposing to establish a single payment pool per state. This approach would establish a single payment allocation per state and each provider would receive a payment on a quarterly or annual basis from the state allocation. We believe that this approach would maximize provider reimbursement, establish payments to providers within a state that reflect each provider's prorated share of the state allocation based on the costs each provider incurred in each quarter, and simplify the administration of this section of MMA.

Other Options Considered

We also considered establishing a distinct provider type payment pool in each state. Under this approach each state's allocation would be set in advance by CMS and separated into three distinct provider allotments. Using a distribution methodology, such as Medicaid payment data, we could divide the total state allocation into three distinct funding pools for hospitals, physicians, and ambulance providers. Thus, hospitals, physicians, and ambulance providers would receive a specified percentage of each state's allotment.

While we also considered establishing distinct payment pools for providers, we do not favor this approach because it unnecessarily limits provider reimbursement in advance of receiving provider payment request. In addition, we believe that this approach would increase the administrative complexity and costs associated with administering these funds.

XII. Submission of Payment Request

[**If you choose to comment on issues in this section, please include the caption "Submission of Payment Request" at the beginning of your comments.**]

Designated Claims Processing Contractor

CMS proposes to designate a single contractor nationally for the purposes of receiving claims, calculating provider payment amounts, and effectuating payments. We believe that a single claims processing contractor will facilitate the effective administration of this section of MMA.

If a provider submits a section 1011 claim to a existing Medicare carrier or fiscal intermediary other than the designated section contractor, the Medicare carrier or fiscal intermediary receiving the section 1011 claim submission will return the claim to the provider.

Claim Submissions

In requesting reimbursement for aliens described in paragraph (c)(5) of section 1011, CMS proposes that providers submit claims within 90 days of the close of the Federal fiscal quarter. Thus, it is important to note that claims will not be paid on a first come, first paid basis, but rather, after all claims from all eligible providers are received for the previous quarter, CMS' designated contractor will begin claims processing and adjudication activities. Because of the statutory mandate that the Secretary issue payments on a quarterly basis and the necessity for finality in the claims process, claims not submitted within a timely manner will be denied.

Basic Requirements for all Section 1011 Claims:

We propose that section 1011 claims meet the following requirements:

1. A claim must be filed electronically with CMS' designated contractor on a form prescribed by CMS in accordance with CMS' Medicare processing instructions. For the purposes of section 1011 reimbursement, CMS will require that a hospital file an electronic UB-92 and that physicians and ambulance providers file an electronic CMS-1500.

2. A claim must comply with the applicable HIPAA standard for the health care claim transaction. In submitting a standard transaction, providers will further the goal of improved health care delivery by reducing the administrative burden and paperwork associated with a section 1011 payment request.

3. A claim must have a date of service beginning on or after October 1, 2004. For the purpose of section 1011 reimbursement, services rendered prior to or initiated before October 1, 2004 are not eligible for reimbursement (THESE ARE COLLECTION REQUIREMENTS THAT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE.)

4. A claim must be filed within 3 months of the end of the federal fiscal quarter (i.e., December 31st, March 31st, June 30th, or September 30th.) Accordingly, if services are rendered on November 15, 2004, a provider must submit a payment request no later than 90 days from the end of that fiscal quarter (i.e., March 31, 2005) in order to receive reimbursement. Failure to submit a payment request within the prescribed time frames will result in a payment denial. This requirement is necessary given that section (c)(3)(D) of section 1011 requires that the Secretary make quarterly payments to eligible providers.

Submission of Medical and other Documentation

Unless specifically requested, CMS is proposing that hospitals and other providers maintain, but not submit medical and non-medical documentation records for reimbursement purposes. Hospitals and other providers are required to maintain medical and non-medical documentation, including relevant information regarding a patient's citizenship status (THESE ARE COLLECTION REQUIREMENTS THAT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE.) This documentation may be requested during a compliance process review, and CMS' designated contractor may review medical and non-medical documentation to determine the accuracy of payments (THIS COLLECTION REQUIREMENT IS EXEMPT FROM THE PRA 5 CFR 1320.4. IT WILL NEED TO BE ADDRESSED IN THE PRA PACKAGE.)

Designated Compliance Contractor(s)

CMS proposes to designate one or more compliance contractors for the purposes of reviewing the medical necessity of submitted claims and the associated medical and non-medical documentation. These contractors may conduct pre-payment or post-payment claim reviews, identify and assess overpayments, if necessary, and ensure compliance with the provisions outlined in this policy paper.

XIII. Determination of Payment Amounts

[**If you choose to comment on issues in this section, please include the caption "Determination of Payment Amounts" at the beginning of your comments.**]

As stated above in section X, Payment Methodology, we propose to use Medicare payment rules to calculate the payment amount for hospital, physician, and ambulance services under section (c)(2)(ii). Indian Health Service facilities and Tribal organizations would also be required to submit valid claim submissions and the payment amount under section (c)(2)(ii) would be paid based on current Medicare payment rules.

Specifically, CMS proposes that hospital inpatient services related to EMTALA would be paid at the lesser of:

(i) the amount that the provider demonstrates was incurred for the provision of such services; or

(ii) amounts determined under a methodology established by the Secretary.

The Secretary's method for estimating payments will consist of determining what the appropriate Medicare payment amount would be if the patient whose services are covered under section 1011 were a Medicare beneficiary, that is to say:

- payment rules using Inpatient Prospective Payment System (IPPS) or the appropriate excluded payment system for inpatient hospital services (including pre-admission bundling and all other payment rules);

- payment rules under the Outpatient Prospective Payment System (OPPS) for hospital outpatient department services not associated with an admission that are related to EMTALA;

- payment rules under the physician fee schedule (that is, service level billing using appropriate CPT/HCPCS codes that we would then convert to claimed payment amounts using the Physician Fee Schedule (PFS) payment rules appropriate for the services billed). In addition, we propose to pay non-participating physicians using 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.

We believe that this approach is consistent with (c)(2)(A) of section 1011.

XIV. Quarterly Payments to Providers

[**If you choose to comment on issues in this section, please include the caption "Quarterly Payments" at the beginning of your comments.**]

Paragraph (c)(3)(D) of section 1011 requires the Secretary to make quarterly payments to eligible providers. For the purposes of implementing this section, we propose to make quarterly payments beginning in April 2005 for services provided to eligible aliens during the 1st quarter of FY 2005 (i.e., services rendered on or after October 1, 2004 through December 31, 2004.) Quarterly payments will be made every three months thereafter and will be made for subsequent federal fiscal quarters in July, October and January.

Proposed Approach:

CMS is proposing to adopt a quarterly proportional payment approach. Under this approach, CMS would seek to make proportional provider payments on a quarterly basis but would not attempt to adjust provider payments within a state on an annual basis. The table below illustrates how provider reimbursement may vary depending on the timing of the reimbursement request, the state funding allocation, and the impact, if any, of a pro-rata reduction. Example:

	QTR 1	QTR 2	QTR 3	QTR 4	Total
Provider A's Approved Charges	0.5 m	1.5 m	2.0 m	1.5 m	5.5 m
Total Approved Charges for All Providers in the State	100 m	50 m	200 m	150 m	500 m
State Allocation ($40 million/year)	10 m	10 m	10 m	10 m	40 m
Ratio of Total Charges to Quarterly Allocation	10 %	20 %	5 %	6.7 %	N/A
Provider A's Payment	0.05 m	0.3 m	0.1 m	0.1 m	.55 m
State Allocation Available during the Annual Reconciliation Process	0	0	0	0	N/A

Note: If at the end of the fiscal year a state has undistributed funds, we would allocate the undistributed funding across all unpaid requests within that state on a proportional basis at the end of the year.

Using the example above, this provider would receive $550,000, or 10 percent of its charges, in total fiscal year payments.

In selecting this approach, we believe that providers would like to receive the maximum payment available within the shortest time period.

Other Options Considered

We also considered establishing quarterly payments with annual proportional payments. Under this approach, CMS would make interim quarterly provider payments, and make any adjustments necessary to ensure proportional provider payments on an annual basis. To avoid overpaying certain providers, CMS would make quarterly payments that represent a fraction of the total reimbursement in any given quarter. During the annual reconciliation process (perhaps 150 – 180 days after the end of the fiscal year), providers would receive an adjustment payment based on their share of total accumulated costs/charges during the fiscal year across all providers. Thus, a provider that submits $5.5 million dollars in approved charges (as adjusted by the payment formula) from a state with a $500 million in total approved adjusted charges, and $40 million in available funding would receive $440,000, or 8 percent, of their total claim.

While we also considered this approach, we do not favor this approach because providers would only receive fractional quarterly interim payments until CMS completed its annual reconciliation, perhaps four to six months after the end of the fiscal year.

XV. Pro-Rata Reduction

[**If you choose to comment on issues in this section, please include the caption "Pro-Rata Reduction" at the beginning of your comments.**]

Paragraph (c)(2)(B) of section 1011 states that if the amount of funds allocated to a state for a fiscal year is insufficient to ensure that each eligible provider in that state receives the amount of payment calculated, the Secretary shall reduce that amount of payment with respect to each eligible provider to ensure that no more than the amount allocated to the State for that fiscal year is paid to such eligible providers.

Based on the statutory language, we believe that when the total value of all payment requests exceeds the total amount available for a specified state allotment that we must recalculate the approved provider reimbursement amount so that each eligible provider will receive some payment for furnishing eligible service and that the sum of all provider payments within a state does not exceed the available state allotment. For example, if CMS' designated contractor calculates that provider payments for a given state will be $40 million, but the state allotment is only $5 million, then each provider would receive 12.5 percent of their approved reimbursement amount.

Since we are unable to predict the number of claim submissions or the value of approved claims for a given state for a particular quarter or fiscal year, we are unable to project whether the pro-rata reduction would be applicable for a given state until we receive actual claim submissions. While the pro-rata reduction will vary from state to state, we expect that some providers will receive only a fractional Medicare payment amount, perhaps as low as 5 or 10 percent of their otherwise approved Medicare reimbursement amount.

XVI. Unobligated State Allotments

[**If you choose to comment on issues in this section, please include the caption "Unobligated State Allotments" at the beginning of your comments.**]

Paragraph (a)(2) of section 1011 requires that, "funds appropriated under this section shall remain available until expended." However since funds are appropriated on a state-by-state basis using a formula described in statute, any unobligated state funds will not be available for redistribution to another state. Accordingly, 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.

XVII. Appeals and Grievances and Claim Adjustments

[**If you choose to comment on issues in this section, please include the caption "Appeals" at the beginning of your comments.**]

We are not proposing to develop a formal appeals and grievance process. Given the expected level of reimbursement for section 1011 payment request, it does not seem cost effective for providers or CMS to establish a formal appeals and grievance process. Moreover, to simplify the administration of this provision, we are proposing that once a claim is processed that it cannot be resubmitted and revised by the provider.

XVIII. Reconciliation Payment Process

[**If you choose to comment on issues in this section, please include the caption "Reconciliation" at the beginning of your comments.**]

CMS proposes to conduct a reconciliation process for each state annually. It is during this process that we will determine if any balance is due or owed by a given provider. Within six months of the close of the FFY, CMS' designated contractor will calculate and disburse, subject to the state maximum, any remaining provider payments for the prior fiscal year. It is during this reconciliation process that CMS' designated contractor will disburse any previously withheld provider payments.

It should also be noted that the reconciliation process does not take the place of a separate compliance review to which the providers may be subject.

XIX. Overpayments

[**If you choose to comment on issues in this section, please include the caption "Overpayments" at the beginning of your comments.**]

We are proposing that each provider participating in the section 1011 project agree to repay any assessed overpayment within 30 days of written notification by CMS' designated contractor, and that failure to repay an overpayment within a timely manner may result in future section 1011 reimbursement being withheld until the overpayment is repaid. Moreover, since provider payments may be redistributed to other providers, we are not proposing to offer an extended repayment plan.

Providers that have been notified of an overpayment will have 30 days to return the overpayment to the CMS designated contractor without accrual of interest. Providers that fail to return overpayments within 30 days will accrue and be responsible for any interest determined to be applicable.

Further, we are proposing that in the event that no additional section 1011 reimbursement is payable and the provider refuses to repay the assessed overpayment within the specified timeframe that CMS or its designated contractor would refer this overpayment to an appropriate debt collection agency or the Department of Treasury.

XX. Compliance Reviews

[**If you choose to comment on issues in this section, please include the caption "Compliance Reviews" at the beginning of your comments.**]

Paragraph (d)(1) of section 1011 provides that the Secretary establish measures to ensure that inappropriate, excessive, or fraudulent payments are not made from the state allotments, including a certification by eligible providers of the veracity of the payment request.

We will conduct medical review and documentation reviews to ensure that claim submissions are supported by the clinical and non-clinical documentation. These audits may be based on identified aberrancies and claims volume.

XXI. Collection of Information Requirements

[**If you choose to comment on issues in this section, please include the caption "Information Requirements" at the beginning of your comments.**]

Later this year, we will solicit public comment when the collection of information requirements referenced in this document is submitted to the OMB for review and approval. In order to minimize the paperwork burden implementation of section 1011, we are soliciting your input on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.

- The accuracy of our estimate of the information collection burden.

- The quality, utility, and clarity of the information to be collected.

- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

The following is a list of the information collection activities that we would propose to implement for section 1011 of the MMA.

- Proposed Information Collection Instrument for Documenting Citizenship (Attachment B);

- Proposed requirement for hospitals and other providers to maintain, citizenship, data and other pertinent documentation records for purposes reimbursement;

- Proposed Information Collection Instrument for Section 1011 Enrollment Application (Attachment C);

- Proposed requirement for hospital notification to physicians that it employs or maintains a contract with its election to receive both hospital and physician payments;

- Proposed requirement for providers to provide CMS, or its designated contractor, necessary financial information to effectuate payments and issue the appropriate tax information;

- Proposed requirement for each enrollee to notify CMS' administrative contractor in writing regarding any change in its bank routing or financial information; and

- Proposed Information Collection for an abbreviated version of the CMS-855 information collection requirements;

- Proposed Claims Processing Approach Utilizing the CMS-1500 or UB-92.

Attachment A

Section 1011 Preliminary State Allocations

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

State	Estimated Unauthorized Resident Population: January 2000	Preliminary State Allocations Based on the Percentage of Undocumented Aliens	Number of Apprehensions by State in FY 2003	Preliminary State Allocation Based on the Number of Alien Apprehensions	Projected State Allocation (Total)
	(thousands)				
Alabama	24	$572,326	757		**$572,326**
Alaska	5	$119,235	278		**$119,235**
Arizona	283	$6,748,679	410,105	$34,831,052	**$41,579,731**
Arkansas	27	$643,867	1,288		**$643,867**
California	2,209	$52,677,852	231,523	$19,663,719	**$72,341,572**
Colorado	144	$3,433,957	7,207		**$3,433,957**
Connecticut	39	$930,030	460		**$930,030**
Delaware	10	$238,469	-		**$238,469**
D.C.	7	$166,928	1,139		**$166,928**
Florida	337	$8,036,413	9,510	$807,704	**$8,844,117**
Georgia	228	$5,437,098	1,788		**$5,437,098**
Hawaii	2	$47,694	508		**$47,694**
Idaho	19	$453,092	1,131		**$453,092**
Illinois	432	$10,301,871	2,721		**$10,301,871**
Indiana	45	$1,073,112	605		**$1,073,112**
Iowa	24	$572,326	486		**$572,326**
Kansas	47	$1,120,805	-		**$1,120,805**
Kentucky	15	$357,704	656		**$357,704**
Louisiana	5	$119,235	4,110		**$119,235**
Maine*	0.5	$11,923	380		**$11,923**
Maryland	56	$1,335,428	1,135		**$1,335,428**
Massachusetts	87	$2,074,682	1,532		**$2,074,682**
Michigan	70	$1,669,285	3,577		**$1,669,285**
Minnesota	60	$1,430,815	2,138		**$1,430,815**
Mississippi	8	$190,775	861		**$190,775**
Missouri	22	$524,632	4,099		**$524,632**
Montana*	0.5	$11,923	1,063		**$11,923**
Nebraska	24	$572,326	2,683		**$572,326**
Nevada	101	$2,408,539	1,213		**$2,408,539**
New Hampshire	2	$47,694	470		**$47,694**
New Jersey	221	$5,270,170	1,963		**$5,270,170**
New Mexico	39	$930,030	49,421	$4,197,426	**$5,127,456**
New York	489	$11,661,145	9,612	$816,367	**$12,477,512**
North Carolina	206	$4,912,466	1,398		**$4,912,466**
North Dakota*	0.5	$11,923	663		**$11,923**
Ohio	40	$953,877	1,320		**$953,877**
Oklahoma	46	$1,096,958	681		**$1,096,958**
Oregon	90	$2,146,223	2,306		**$2,146,223**
Pennsylvania	49	$1,168,499	3,374		**$1,168,499**
Rhode Island	16	$381,551	736		**$381,551**
South Carolina	36	$858,489	342		**$858,489**
South Dakota	2	$47,694	395		**$47,694**
Tennessee	46	$1,096,958	1,415		**$1,096,958**
Texas	1,041	$24,824,647	267,081	$22,683,733	**$47,508,379**
Utah	65	$1,550,050	2,503		**$1,550,050**
Vermont*	0.5	$11,923	1,158		**$11,923**
Virginia	103	$2,456,233	406		**$2,456,233**
Washington	136	$3,243,181	4,564		**$3,243,181**
West Virginia	1	$23,847	169		**$23,847**
Wisconsin	41	$977,724	491		**$977,724**
Wyoming	2	$47,694	-		**$47,694**
Total	**7,003**	**$167,000,000**	**977,252**	**$83,000,000**	**$250,000,000**

Source: Department of Homeland Security (DHS), Office of Immigration Statistics.

[1] These are preliminary estimates based on FY 2003 apprehension data. Final allocations will change based final DHS data.

* States that had less than 1,000 estimated aliens received values of .5 (500 illegal aliens)

Attachment B: Proposed Information Collection Instrument for Documenting Citizenship

Section 1011 Payment Request Screening Check List

The information collected from this form will be used to help determine whether your health care provider is eligible to receive Federal reimbursement for the care you have received.

Providers must maintain acceptable evidence to qualify for payment under Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

REQUESTS FOR DOCUMENTATION SHOULD NOT DELAY SCREENING AND STABILIZATION SERVICES REQUIRED UNDER EMTALA.

Patient Name: _____

Patient Address: _____

_____

Patient Telephone Number: _____

Patient Place of Birth: _____

1. **Are you a United States Citizen (Y/N)? ____; Decline to Answer (☑)? ____**

   If Yes, a section 1011 payment is not available for this patient.

   If No or patient declines to answer, go to 2 below.

2. **Are you a lawful permanent resident, an alien with a valid and current I-688B (Employment Authorization Card), or other qualified alien (Y/N)? __; Decline to Answer (☑)? ____**

   If Yes, a section 1011 payment is not available for this patient.

   If No, or patient declines to answer, go to 3 below.

3. **Are you in the United States on a non-immigrant VISA (includes students, tourist, businessman, etc) (Y/N)? __; Decline to Answer (☑)? ____**

   If Yes, a section 1011 payment is not available for this patient.

   If No, or patient declines to answer, go to 4 below.

4. **Are you a foreign citizen that has been admitted to the U.S. with a 72-hour border crossing card (i.e., laser visa, Form DSP-150) (Y/N)? __; Decline to Answer (☑)? ___**

   If Yes, a section 1011 payment may be applicable. Include a copy of the patient's laser visa in the financial file.

   If No or patient declines to answer, go to 5 below.

5. **Have you been paroled into the United States for the purposes of receiving eligible services and have a Form I-94 (Y/N)? _____; Decline to Answer (☑)? _____**

   If Yes, a section 1011 payment may be applicable. Include a copy of the patient's parolee information in the financial file.

   If No or patient declines to answer, go to 6 below.

6. Do you have a Social Security Number or health insurance policy number (Y/N)? ___; Decline to Answer (☑)? ___

If Yes, go to 7 below.

If No or patient declines to answer, go to 8 below.

7. For the purposes of medical reimbursement, please provide the following information.
Social Security Number (SSN): _____
Medicaid or health insurance policy number: _____

==========

8. Completing the following questions will help you determine whether federal reimbursement is available for this patient's care. In the course of interviewing a patient, you are encouraged to obtain the information necessary to complete the following questions:

a) The patient has informed me that he/she is an undocumented alien. Note: If the patient informs you that he or she is an undocumented alien, then no additional information is required to establish the patient's citizenship status. Check (☑) **"**Yes" only if the patient has stated that he or she is an undocumented alien. Yes ____

b) The combination of an alleged foreign place of birth and one of the following documents can be used as an affirmative demonstration of immigration status. Please check (☑) all of the following that apply and attach a photocopy of the document, if available, to establish payment eligibility.

__ Foreign Passport, Visa, or Foreign Driver's License
__ Foreign Voting Card or Foreign Bank Account(s)
__ Foreign Identification Card (including "Matricula Consular")
__ Boarder Patrol Drop-off

c) The combination of an alleged foreign place of birth and two pieces of missing or faulty demographic information can be used as an affirmative demonstration of immigration status. Please check (☑) all of the following that apply.

__ Missing or Invalid Social Security number
__ Missing or Invalid U.S. Driver's License
__ No health insurance coverage, including Medicaid or Medicare

Notice: I certify that the information provided is true and complete to the best of my knowledge and belief.

PROVIDER REPRESENTATIVE DATE AND SIGN HERE

DATE: _____

SIGNATURE: _____

Attachment C:
Section 1011 Enrollment Application

1. Applicant Legal Name	**2. Date Submitted**
3. Address (city, county, state, zip code)	**4. Name, telephone number and address of person to be contacted on matters involving the application.**
5. State of Service (Note: a separate application must be submitted for each state of operation.)	**6. Current Medicare Fiscal Intermediary or Carrier**
7. Type of Applicant (Check one) Hospital _____ Physician _____ Ambulance _____	**8. Applicant's Medicare UPIN** Hospital _____ Physician _____ Ambulance _____

9. Hospital Election (Hospital Only)

_____ Payment for Hospital and Physician Services (Hospitals electing to receive payment for both hospital and physician services must complete Attachment 1.)

_____ Payment for hospital and a portion of on-call payments made by the hospital for physician services.

10. Physician Privileges (Physician Only)

If a physician has privileges at multiple hospitals, then the physician must complete Attachment 2.

11. Applicant's Federal Tax Identification Number	**12. Applicant's Routing Transit Number, Deposit Account Number & Type of Account (C/S)**

ALL PROVIDERS

In order to receive payment under section 1011 of the Medicare Modernization Act of 2003, the provider submitting this enrollment application agrees to collection requirements approved under the Paperwork Reduction Act. This agreement, upon submission by the provider of services, and upon acceptance by the Secretary of Health and Human Services, shall be binding on the provider of services and the Secretary.

Within 30 days of written notification from the Centers of Medicare & Medicaid Services' designated contractor, I agree to fully reimburse the Federal government for any assessed overpayment.

HOSPITALS ONLY

I agree to provide citizenship status information to physicians and ambulance providers within 60 days of the date of service. If I have elected to receive section 1011 payments for both hospital and physician services (see item 9 above), I agree to notify the physicians within my hospital about this election. I further agree to reimburse physicians in a prompt manner after receiving section 1011 reimbursement and agree not to charge an administrative or other fee with respect to transferring reimbursement to a physician.

ATTENTION: READ THE FOLLOWING PROVISION OF FEDERAL LAW CAREFULLY BEFORE A SIGNING.
Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or use any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C section 1001).

To the best of my knowledge and belief, all data in this application are true and correct, and the governing body of the applicant has duly authorized the document.

13. Type Name and Title of Authorized Representative	**14. Telephone Number**
15. Signature of Authorized Representative	**16. Date**

This application provides an opportunity for eligible providers to apply to receive reimbursement for their un-reimbursed costs of providing services required by section 1867 if the Social Security Act and related hospital inpatient and outpatient services furnished to undocumented alien, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U. S. with a laser visa.

APPLICATION SUBMISSION An original copy of the APPLICATION must be submitted within 30 days of the close of a Federal fiscal quarter. Applications should be MAILED to the following address:

(NOTE: OMB HAS NOT APPROVED THIS INFORMATION COLLECTION. PLEASE DO NOT SUBMIT THIS FORM UNTIL OMB REVIEWS THIS INFORMATION COLLECTION.)

Because of staffing and resource limitations, and because we require an application containing an original signature, we cannot accept applications by facsimile (FAX) transmission. Applications must be typed or completed in ink.

APPLICATION REQUIREMENTS We will use all the information you submit for enrollment and claims validation purposes.

Complete, sign, date, and return the Section 1011 Enrollment Application found at the beginning of this application

FINANCIAL INFORMATION The information concerning your financial institution should be available through your organization's treasurer or financial institution. A contact person and telephone number are important for verification purposes. Your financial institution can assist you in providing the correct banking information, including the bank's routing number.

FOR FURTHER INFORMATION Please contact the project officer listed above.

Attachment 1

Section 1011 Enrollment Application

This attachment is only required for hospitals electing to receive section 1011 payment for hospital and physician services. Hospitals must list the names and Unique Provider Identification Number (UPIN) of physicians with hospital privileges.

Physician's Name	Physician's UPIN

Attachment 2

Section 1011 Enrollment Application

This attachment is only required for physicians with privileges at more than one hospital.

Physicians with hospital privileges at more than one hospital must list the name and address of each hospital where they have privileges.

Hospital's Name	Hospital's Address