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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare and Medicaid Services

[Document Identifier: CMS-10130]

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Center for Medicare & Medicaid Services

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, submitted the following collection for emergency review and approval.

We requested an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR Part 1320. This is necessary to ensure compliance with provisions of Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). We cannot reasonably comply with the normal clearance procedures because of the effective implementation date associated with this provision of MMA.

OMB evaluated the collection for necessity and utility of the proposed information collection for the proper performance of the agency's functions; the accuracy of the estimated burden; ways to enhance the quality, utility, and clarity of the information to be collected; and the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

OMB approved the emergency review of the information collection referenced below on May 9, 2005. OMB approved CMS' request for the information collection titled, "Federal Funding of Emergency Health Services (Section 1011): Provider Payment Determination and Request for Section 1011 Hospital On-Call Payments to Physicians" (OMB#:0938-0952) for a 180-day approval period.

Background

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 made 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 United States 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. Note: On August 13, 2004, the Department of Homeland Security, Bureau of Customs and Border Protection, published an interim final rule extending the time limit for border crossing card visitors from 72 hours to a period of 30 days.

Type of Information Collection Request: New collection; Title of Information Collection: Federal Funding of Emergency Health Services (Section 1011): Provider Payment Determination and Hospital On-Call Payment Form and Related Instructions. Use: The provider payment determination form will be used to determine whether a patient's health care provider is eligible to receive Federal payment under section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003; allow hospitals and other providers to make an affirmative determination regarding a patient's section 1011 eligibility; allow CMS to verify that the hospital, physician or provider of ambulance services has obtained the necessary documentation to ensure claim payment.

Hospitals electing to receive payments under section 1011(c)(3)(C)(ii) will use the hospital on-call payment form to determine a their on-call costs. Form Number: CMS-10130 (OMB#: 0938-0952); Frequency: Other: as needed; Affected Public: Business or other for-profit, Not-for-profit institutions, and State, Local or Tribal Govt.; Number of Respondents: 7,503,000 Total Annual Responses: 7,512,000; Total Annual Hours: 634,000

Final Implementation Notice:

Readers can find CMS' final implementation notice for this program attached to this notice and at http://www.cms.hhs.gov/providers/section1011.

For Further Information Contact:

Jim Bossenmeyer, (410) 786-9317.

To obtain copies of the supporting statement for this information collection, CMS' final implementation approach, and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at http://www.cms.hhs.gov/regulations/pra/, or E-mail your request, including your address, phone number, OMB number, and CMS document identifier, to Paperwork@cms.hhs.gov, or call the Reports Clearance Office on (410) 786-1326.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

SUBJECT: Center for Medicare & Medicaid Services Final Implementation Notice: Federal Funding of Emergency Health Services Furnished to Undocumented Aliens: Federal Fiscal Years 2005 Through 2008

This notice provides the Centers for Medicare & Medicaid Services (CMS) final implementation guidance with respect to section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, 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).

The guidance provided below sets forth CMS' implementation approach, establishes the general framework and procedural rules for submitting an enrollment application and payment requests, establishes general statements of policy, and provides CMS' interpretation of section 1011.

Future Program Changes

Since section 1011 payments are authorized for 4 years, CMS will monitor its implementation approach in future years and, if necessary, make the necessary

adjustments to improve the accuracy and timeliness of payments to providers, ensure patient access to emergency services, and reduce administrative costs for providers.

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 Legislative Summary

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 made 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 United States 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. Note: On August 13, 2004, the Department of Homeland Security, Bureau of Customs and Border Protection, published an interim final rule extending the time limit for border crossing card visitors from 72 hours to a period of 30 days.

II. Provisions of CMS' Final Implementation Guidance. This paper is divided into the following sections.

Section	Section Title
III	Determination of Annual State Allotments for FY 2005 – FY 2008
IV	Eligible Providers
V	Eligible Aliens
VI	Covered Services
VII	Enrollment Application Process

Section	Section Title
VIII	Reimbursement from Third-Party Payers and Patients
IX	Patient Eligibility Determination
X	Payment Methodology
XI	Distribution of State Funding to Providers
XII	Submission of Payment Requests
XIII	Determination of Payment Amounts
XIV	Pro-Rata Reduction
XV	Quarterly Payments
XVI	Appeals and Claim Adjustments
XVII	Compliance Reviews
XVIII	Overpayments
XIX	Annual Reconciliation Process
XX	Unused State Funding

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

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 and certain other aliens.

This paper provides Federal fiscal year (FFY) 2005 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 2005 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 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 adopted a position 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." Since section 1011 (b)(2)(C)

requires that we use data from the four consecutive quarters ending before the beginning of the fiscal year, we are adopting a position 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. However, due to changes in the way the Department of Homeland Security collects alien apprehension data, there is not complete data available for that period of 4-consecutive quarters. As a result, for FY 2005 allocations 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 April 1, 2003 to March 31, 2004. For future fiscal year allocations, we plan to use the 4-consecutive quarters for which information is available, which should be July 1-June 30.

Our analysis, using apprehension data from DHS from April 1, 2003 to March 31, 2004, indicates that the six states with the highest number of undocumented alien apprehensions were Arizona, California, Florida, New Mexico, New York, and Texas.

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 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 believe 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 (April 1, 2003 to March 31, 2004. 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 April 1, 2003- March 31, 2004, compared to the total of such apprehensions for all six states for the period of April 1, 2003- March 31, 2004.

For purposes of determining the allocation for the six states in subsequent fiscal years, 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.)

Final FY 2005 State Allocations

Attachment 1 contains the final state funding allocations for FY 2005. The state specific allocation of the $167 million is based on already available data required to calculate the funding amounts and remain unchanged for each fiscal year (FY 2005-FY 2008). The six state allocations of the $83 million may change on yearly basis, so the allocations may change in FY 2006 – FY 2008. Updated allotments for the $83 million for FY 2006-2008 will be determined before the start of each fiscal year.

Public Comments

In response to several comments that suggested that state funding allocations be redistributed from one jurisdiction (i.e., State or the District of Columbia) to another jurisdiction, CMS is adopting a position that section 1011(b) of the MMA establishes a funding allocation for each jurisdiction identified in (e)(6) and that the funding allocation

is not subject to revision by CMS. Moreover, we believe that the statutory language contained in section 1011(e)(6) of the MMA precludes payment for services furnished in Guam, Puerto Rico, and other U.S. Territories. Therefore, we are unable to adopt the recommendation to redistribute state allocations established by section 1011.

IV. Eligible Providers

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) are considered eligible providers.

"Hospital" is defined at section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)). The term "Hospital" generally includes 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, we are adopting a position that 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). The term "Physician" includes doctor of medicine (MD), doctor of osteopathy, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, doctors of optometry, chiropractors, or doctors of dental surgery.

While section 1011 does not define a "provider of ambulance services," we are adopting a position that a state-licensed "provider of ambulance services" for covered emergency transportation services is eligible for payment for covered transports to a hospital emergency department or from one 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).

Public Comments

Several commenters recommended that Federally Qualified Health Centers (FQHCs) and mid-level practitioners, including nurse practitioners, physician assistants, and clinical nurse specialists, be allowed to seek section 1011 payment. Since section 1011 clearly specifies that only physicians, as defined in 1861(r) of the Act (42 U.S.C. 1395x(r), are eligible to bill for emergency services furnished to individuals identified in (c)(5), mid-level practitioners, including nurse practitioners, clinical nurse specialists, and physician assistants, are not eligible to receive payments under section 1011 for the emergency services provided. Moreover, we believe that the statutory language contained in section 1011(e)(4) of the MMA excludes FQHCs from receiving payment for section

1011 emergency services, unless the FQHC meets the definition of a hospital in 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

V. Eligible Aliens

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

- Undocumented Aliens (Section 1011 does not define the term "undocumented alien." For the purposes of implementing this section of MMA, the term "undocumented alien" refers to a person who enters the United States without legal permission or who fails to leave when his or her permission to remain in the United States expires); or

- Aliens who have been paroled into the United States at a United States port of entry for the purpose of receiving eligible services (In general, parole authority allows the Department of Homeland Security to respond to individual cases that present problems for which no remedies are available elsewhere in the Immigration and Nationality Act. Parole is an extraordinary measure sparingly used to bring otherwise inadmissible aliens into the United States for a temporary period of time due to a very compelling emergency. The prototype case arises in an emergency situation. For example, the sudden evacuation of U.S. citizens from dangerous circumstances abroad often includes household members who are not citizens or permanent resident aliens, and these persons may be paroled. When aliens are brought to the United States to be prosecuted or to assist in the prosecution of others, they are paroled.); 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)).

On August 13, 2004, the Department of Homeland Security, Bureau of Customs and Border Protection, published an interim rule with request for comments (69 Fed Reg. 50051) expanding the time restriction on border crossing cards used by Mexicans to enter the United States for temporary visits. The new rule extends the time limit for border crossing card visitors from 72 hours to a period of 30 days. Previously, border-crossing cardholders could visit the United States for 72 hours within a border zone of 25 miles along the border in Texas, New Mexico, and California and 75 miles of the border in Arizona. The geographic limitations remain unchanged.

Public Comments

One commenter recommended that an eligible provider be allowed to claim section 1011 payments for foreign nationals possessing a non-immigrant visa. Since the statutory language does not permit payment for foreign nationals and other immigrants not identified in section 1011(c)(5) of MMA, we are not adopting this recommendation.

VI. Covered Services

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 should 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). Because section 1011 includes payment for both related inpatient and outpatient services, we believe that in the context of this new program the statute can be reasonably interpreted to include the associated physician services at the hospital that are related to EMTALA.

Section 1867(e) of the Social Security Act defines the term "emergency medical condition" as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or unborn child.

Initial Proposal

Initially, we proposed that section 1011 coverage would end when a patient was discharged from the hospital. While this approach would impose the least amount of burden on hospitals since no splitting of costs/charges or other information would be needed to determine payments during a stay, we now believe that this approach is overly expansive and may not fully comport with the intent of Congress to limit the coverage criteria. Thus, by adopting our final implementation approach that permits payment for services furnished until the patient is stabilized, we believe that we are focusing payment on EMTALA and the most closely related EMTALA services. The primary point of the EMTALA services is to stabilize the patient in an emergency rather than to cure the underlying illness or injury.

Other Options Considered

We considered several other options in our initial proposal. 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. In adopting a position that covers services provided through stabilization, we believe, in general, the most intensive procedures or services required for an emergency patient would be those furnished during the earliest part of a stay. In some cases, however, stabilization may take longer, so we are adopting a final approach that will permit payments beyond a fixed time period in some circumstances. We believe this more flexible approach will more accurately reflect the services that hospitals and physicians furnish to patients prior to stabilization.

Finally, we considered 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.

Public Comments

Several commenters recommended that we limit inpatient coverage to a defined period of time after an inpatient admission. Specifically, these commenters recommended that CMS more closely tie section 1011 coverage to patient stabilization. In addition, these commenters asserted that extending inpatient coverage through discharge would accelerate the depletion of the program's limited financial resources, could encourage fraud and abuse, and may result in the hospitals providing services unrelated to the emergency condition for which the patient was admitted. We appreciate these comments and agree that providing coverage through stabilization is consistent with Congressional intent.

Final Implementation Approach

For hospital services, we are adopting a position that payment will be made for covered services that 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 will begin when the individual arrives at the specialty hospital.

For hospital services, we are also adopting a position that section 1011 coverage continues 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 will continue until the individual is stabilized. For an inpatient of either hospital, this could 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.

To be considered stable, a patient's emergency medical condition must be resolved, even though the underlying medical condition may persist. For example, an individual presents to a hospital complaining of chest tightness, wheezing, and shortness of breath and has a medical history of asthma. A physician completes a medical screening examination and diagnoses the individual as having an asthma attack which is an emergency medical condition (EMC). Stabilizing treatment is provided (medication and oxygen) to alleviate the acute respiratory symptoms. In this scenario the EMC was

resolved, but the underlying medical condition of asthma still exists. After stabilizing the patient, the hospital no longer has an EMTALA obligation. The physician may discharge the patient home, admit him/her to the hospital, or transfer (the "appropriate transfer" requirement under EMTALA does not apply to this situation since the patient has been stabilized) the patient to another hospital depending on his/her needs or request.

In general, we believe that most patients are stabilized within 2 calendar days. We believe that EMTALA-related services are all those medically necessary inpatient services that occur prior to stabilization. (For example, a patient that is admitted after midnight on May 10th would most likely be stabilized before midnight on May 11th.) In conjunction with our adopted payment methodology, we are adopting a position to review inpatient admissions that go beyond 2 calendar days. As a matter of enforcement discretion when conducting reviews of claims, we will not review the stabilization determination for those claims for which stabilization occurs on the first or second day. Hospitals need not document when stabilization occurred in these cases. We may review cases where stabilization is determined to have occurred on the third or later day of the admission. In the event we review the claim, we would expect the medical record to completely document the reasons for the stabilization determination. If a determination were not properly documented, we would deem stabilization to have occurred on the second day of the stay. Accordingly, hospitals would need to determine how many days an individual was in the hospital before stabilization occurred. The hospital would then receive a per-diem rate for that individual for each day of the stay, not to exceed the full DRG payment. The per diem rate is calculated by dividing the full DRG payment by the

geometric mean length of stay for the DRG. However, it is worth noting that the per diem rate is still subject to the pro-rata reduction discussed in section XV.

While this approach may impose additional administrative burdens on hospitals, we believe that this coverage approach is more consistent with Congressional intent of limiting the duration of covered services to stabilization. In adopting this approach, we believe that we will reduce the potential of the pro-rata reduction discussed in section XV. Further, we believe that limiting coverage through stabilization, rather than through discharge, will prevent hospitals from seeking 1011 funds for services unrelated to the emergency medical condition.

For physician services, we are adopting a position to cover all medically necessary and appropriate services which physicians furnish to a hospital inpatient or outpatient who receives emergency services required by section 1867 (EMTALA) or "related' inpatient or outpatient services, as defined above; that is, through stabilization. Our reasons for planning to adopt that coverage option for hospital services are explained further above. As noted above, "physician" is defined at section 1861(r).

We are adopting a position that 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 are adopting a position that covers all medically necessary air and/or ground 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 air/and or ground ambulance transportation of a patient that is necessary to effect an appropriate transfer under EMTALA. We are adopting a position that we will not cover the transportation costs associated with transporting patients once emergency care is provided. Although air and/or ground 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.

VII. Enrollment Application Process

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 is adopting a position that each provider electing to receive section 1011 payments must submit a paper enrollment application and an electronic enrollment application prior to submitting a payment request.

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 will:

- Identify a provider's potential interest in seeking payment under section 1011, but will not require the provider to seek payment;

- Allow hospitals to make a payment election, as required by section 1011(c)(3)(C);
- Allow CMS' designated contractor to obtain necessary financial information to effectuate payments and issue the appropriate tax information;
- Establish the state of service for each provider. This will assist CMS in making provider payments from the appropriate state allocation;
- Allow CMS to verify whether the hospital, physician or provider of ambulance services is currently enrolled as a Medicare provider;
- Advise hospitals to notify physicians of its election under (c)(3)(C) of section 1011;
- Advise hospitals electing hospital and physician payments to provide reimbursement to physicians in a prompt manner;
- Inform hospitals of the statutory provisions that prohibit a hospital 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));
- Acknowledge the provider's obligation to repay any assessed overpayment within 30 days of notification by CMS; and,
- Inform a provider about applicable Federal laws relating to submission of false claims.

Accordingly, we are adopting a position that an abbreviated enrollment application must be submitted electronically via a secure website established by our

designated contractor and that an original copy of the enrollment application must be submitted to CMS' designated contractor for verification purposes.

On May 9, 2005, the OMB approved the provider enrollment information collection instrument and related instructions. The provider enrollment application can be found at http://www.cms.hhs.gov/providers/section1011.

Enrollment Process and Application for Medicare Participating Providers

Any hospital, including those operated by the Indian Health Service and Indian tribes and tribal organizations, enrolled in the Medicare program and seeking payment must submit an enrollment application to participate in the section 1011 program.

Further, as stated above in section IV of this paper, because section 1867 of the Social Security Act establishes legal obligations only for hospitals participating in the Medicare program, only Medicare participating hospitals can furnish "services required" by section 1867, we are adopting the position that only Medicare participating hospitals can apply to receive funds under section 1011.

Hospitals' Election

We are adopting a position that hospitals electing to receive payment for both hospital and physician services under (c)(3)(C)(i) will not be allowed to submit claims from certain physicians while allowing other physicians to bill separately. Accordingly,

hospitals electing to receive payments under (c)(3)(C)(i) must receive payment for all physicians employed by or contracted with the hospital.

Submission of Enrollment Application for Medicare Participating Providers

Medicare providers are required to submit an abbreviated enrollment application and an electronic section 1011 enrollment application. Once the section 1011 web-based enrollment process is established, Medicare providers will be notified. Once established, Medicare providers may submit their electronic enrollment application at any time, but at least 30 days prior to submitting a claim. Since Medicare participating providers already have electronic data interchange agreements (EDI) with their existing carrier or fiscal intermediary, we are adopting a policy that no additional agreement be signed. If the provider does not have an EDI agreement, the provider will need to complete an EDI agreement. Finally, we are adopting a position that a provider would be eligible for payment if the designated contractor approves an abbreviated enrollment application in advance of quarterly claims processing activities.

Enrollment Process and Application for Non-Medicare Participating Providers

We are adopting a position that a physician or provider of ambulance services not currently enrolled in the Medicare program submit a completed Medicare enrollment application (i.e., a CMS-855I for physicians or a CMS-855B of a provider of ambulance services) and sign an EDI agreement prior to submitting a section 1011 abbreviated enrollment application and electronic section 1011 enrollment application. If the

provider does not have an EDI agreement, the provider will need to complete an EDI agreement.

The designated contractor will review and approve/deny the Medicare enrollment application prior to reviewing the section 1011 abbreviated enrollment application request. Note: A physician or provider of ambulance services need not enroll in the Medicare program in order to receive section 1011 payment. 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.

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 adopting a position that participating section 1011 providers notify CMS' designated contractor in writing regarding any change in its bank routing or financial information. We believe that this approach will ensure the efficient and effective administration of the statute.

VIII. Reimbursement from Third-Party Payers and Patients

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 are adopting a position that each provider seek reimbursement from all available funding sources, including, if applicable, Federal (e.g., Department of Homeland Security), State (e.g., Medicaid or State Children's Health Insurance Program), third-party payers (e.g., private insurers or health maintenance organizations), or direct payments from a patient, prior to requesting a section 1011 payment. 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.

Use of Existing Practices and Procedures to Identify Reimbursement Sources

We are adopting a position that hospitals and other providers use their existing practices and procedures to identify and request reimbursement from all available funding sources prior to requesting a section 1011 payment.

Impact of Medicaid Payments

Consistent with 42 CFR § 447.15, Medicaid payments will be considered payment in full and providers are only allowed to submit a request for section 1011 reimbursement for the deductible, coinsurance or co-payment not paid by the individual.

42 CFR § 447.15 states, "A state plan must provide that the Medicaid agency must limit participating in the Medicaid program to providers who accept, as payment in full, the amounts paid by the agency plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual. However, the provider may not deny services to any eligible individual on account of the individual's inability to pay the cost-sharing amount imposed by the plan in accordance with 431.55(g) or 447.53. The previous sentence does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the cost sharing charge."

Impact of Department of Homeland Security Payments

Consistent with US Code Title 18, Part III, Chapter 301, Section 4006, we are adopting a position that payments made by the Department of Homeland Security are deemed to be full and final payment.

Impact of Workers Compensation Payments

Subject to limitations imposed by state law, we are adopting a position that providers may balance bill a patient after receiving a worker's compensation payment or determining that a workers' compensation payment may be made on behalf of the patient. In addition, subject to limitations imposed by state law, we are adopting a position that allows a provider to bill section 1011 for unpaid workers' compensation co-payments and deductibles.

Impact of Payments from a Patient

To the extent that there is no third-party payer and an eligible patient self-pays for his or her care, CMS is adopting a position that a provider be allowed to "balance bill" section 1011 in the aforementioned situation for claims that are not fully paid by the patient. In addition, a provider may balance bill the patient for the appropriate costs after a section 1011 payment has been made.

Impact of Grants and Gifts

We are adopting a position that state and local indigent or charity care programs or state funded subsidies are not to be considered in determining whether a third-party payment is applicable.

Impact of Section 1011 payments on the Medicare Cost Report

We are adopting a position that hospitals should not report section 1011 payments on their Medicare cost report.

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

We are adopting a position that if a hospital or other provider receives a payment from a third-party payer subsequent to a section 1011 payment that the provider notify the CMS' designated contractor. An overpayment may occur if a provider receives payments in excess of the approved payment amount. In some cases, a provider may

receive a combination of third-party payment and section 1011 payment that exceed the approved payment amount.

IX. Patient Eligibility Determination

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 a patient's eligibility.

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 federal, state, or private insurance. In some cases, a patient is neither insured nor financially able to pay for his or her care. If a patient has no

other insurance and is unable to pay for treatment, many hospitals will attempt to enroll the patient in Medicaid.

In general, section 1903(v)(1) of the Social Security Act limits Medicaid eligibility to aliens who meet certain immigration status requirements. However, all aliens (including undocumented aliens) are eligible for treatment of an emergency medical condition, provided that they meet all other Medicaid eligibility requirements. In other words, all aliens are eligible for emergency Medicaid coverage only if, except for immigration status, they meet Medicaid eligibility criteria applicable to citizens. For citizens and non-citizens to qualify, they must belong to a Medicaid-eligible "category" such as children under 19 years of age, parents with children under 19, or pregnant women – and meet income and state residency requirements.

We believe that hospital eligibility specialists are sufficiently knowledgeable to avoid asking patients to complete a Medicaid application when the individual has provided information that would deem the patient "categorically ineligible" for Medicaid benefits. Patients generally considered "categorically ineligible" include non-disabled adults and adults without minor children. Moreover, while undocumented aliens have little or no incentive to provide information regarding their citizenship status, it should be noted that categorically eligible immigrants have a strong incentive to demonstrate that they qualify to receive Medicaid.

Government Accountability Office Findings

In May 2004, the Government Accountability 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."

Initial Proposal

Initially, we proposed that a patient specific approach that required hospitals and other providers to request direct eligibility information from patients. In response to the

public concerns regarding the negative public health consequences of asking for this information, we have decided not to ask hospitals and other providers to ask a patient if he or she is a citizen of the United States.

Other Options Considered

We considered two other provider eligibility documentation options. We 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 considered this option, we do not favor this approach because these options do not adequately document the eligibility 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 or survey for the services provided to aliens defined in (c)(5). Moreover, we do not believe that any proxy methodology mentioned to date demonstrates a high correlation to providing emergency services for undocumented and other specified aliens.

Final Implementation Approach

In considering how providers will identify and document patient eligibility 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.

Since section 1011 payments are authorized only for the three categories of non-citizens specified in (c)(5) of section 1011, it is important to establish a process that helps to ensure that hospitals and other providers will received payments only for those three categories of individuals. Accordingly, we are adopting an indirect patient-based documentation approach. Using this approach, providers would request information about a patient's eligibility 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 patient eligibility.

In documenting eligibility, a provider may use a Medicaid enrollment application or another existing information collection instrument. In documenting the eligibility of a minor child, the provider must determine if Medicaid or the State Children's Health Insurance Program would be available for the child's treatment. 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 to obtain the necessary information regarding a patient's eligibility. In the event that a state's Medicaid enrollment application or another existing information collection instrument does not contain the information 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 approved collection instrument.

On May 9, 2005, the OMB approved the provider payment determination information collection instrument and related instructions. The provider payment determination form can be found at http://www.cms.hhs.gov/providers/section1011.

In adopting this approach, we have designed the information collection instrument to minimize its intrusiveness and therefore to minimize the extent to which it discourages persons from seeking needed emergency services. Similarly, we believe the final design minimizes the administrative burden on providers as much as is feasible while still providing CMS with information needed for accurate section 1011 reimbursement of services**.** While we are not requiring that providers use the information collection instrument designed by CMS, we are adopting a position that would require that providers collect and maintain the same information contained in the provider payment determination 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 patient eligibility determination by supplementing their existing collection instruments or a provider may use the provider payment determination information collection instrument as the basis of its eligibility determination. In either case, a provider must collect and maintain all of the information contained in the approved information collection.

Provider associations and patient advocacy organizations raised a number of concerns regarding CMS' proposed implementation approach of asking patients to directly respond to the questions regarding their eligibility status. To mitigate these concerns and the potential negative health consequences of patients not seeking emergency care when it is needed, we are adopting an indirect measure to determine patient eligibility status. By establishing an indirect measure of patient eligibility, we believe that providers will be able to make an affirmative determination regarding a patient's eligibility without directly asking the patient about his or her eligibility status.

We believe that asking a patient to state that he or she is an undocumented alien in an emergency room setting may deter some patients from seeking needed care. Moreover, if providers were required to request a Social Security number or other independently verifiable information from a patient, providers would need a mechanism to verify the authenticity of the information submitted.

Given the numerous concerns raised about CMS' proposed patient-specific documentation approach, we believe that providers are more likely to receive accurate answers to the indirect questions, thus increasing the accuracy of patient eligibility determinations. We believe that revising our patient-specific eligibility documentation approach will limit the number of incorrect payment determinations made by hospital staff and other providers. Finally, we believe that adopting an approach based on indirect questions offers several significant advantages over the proposed implementation

approach, including improving section 1011 payment accuracy, simplifying the patient eligibility information collection requirements for providers, and reducing provider associations' and patient advocacy organizations' concerns about potential adverse public health effects.

Finally, it is important to emphasize that emergency treatment should not be delayed to gather information contained on CMS' information collection instrument or any other existing collection instrument used by a provider to document a patient's eligibility. Moreover, if a provider decides to collect and maintain information regarding the name and badge number of a Federal or State Officer/Agent who brings a patient to the emergency department, that information should be gathered in a way that does not delay emergency medical treatment.

Completing the Provider Payment Determination

In determining a patient's eligibility status, a provider is responsible for completing and signing the provider payment determination and obtaining the documents to affirmatively determine patient eligibility. If a patient refuses to or is unable to provide the proof of eligibility, then the provider should not submit an individual claim or bill for the services rendered (see section XIII, Determination of Payment Amounts, Determination of Payment for Undocumented Uncompensated Care, for additional information regarding payments to providers for undocumented uncompensated care.)

Protected Information

The sole purpose for requesting information contained on the Provider Payment Determination form is to obtain the information necessary to determine provider payment. Since section 1011 payments are only available to certain providers who furnish emergency and related services to patients identified in section (c)(5), we are adopting a position that providers initially determine whether payment is applicable for the services rendered to an individual patient.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule directs "covered entities," which includes providers that electronically transmit health information in connection with covered transactions, to protect certain personal health information of individuals, including undocumented aliens. The Privacy Rule identifies and explains permitted and required uses and disclosures of the information. Among its provisions, it allows covered entities to use and disclose to other covered entities protected health information for payment purposes, under specified conditions. Payment is defined to include coverage or eligibility determination activities related to the individual to whom health care is provided.

Protecting Patient Information – Use of Existing Provider Practices and Procedures

We are adopting a position that when responding to these information requests, covered providers, including covered hospitals, follow the HIPAA Privacy Rule requirements relating to uses and disclosures for payment purposes and, as applicable,

their own privacy practices. If complying with these requests constitutes a material change to a covered provider's privacy practices, that provider must also revise and distribute its privacy practices notice according to 45 CFR 164.520.

Protecting A Patient's Civil Rights

Hospitals and other providers should not assume that an individual is an undocumented alien based on a patients' ethnicity and their inability to pay for emergency services. 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, 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 patient eligibility. Accordingly, hospital and other provider personnel may not selectively screen individuals regarding their eligibility status, on the basis of race, color, or national origin.

As a reminder, we encourage hospitals and other providers to review their existing Title VI policies and practices to ensure that all patient rights are protected.

Attestation and Maintenance of Eligibility Information

We are adopting a position that providers make a good faith effort to obtain correct eligibility information and attest to the fact that the information was correct to the best of their knowledge and belief. Since section 1011 funds are limited and section 1011 funding is available for only the individuals identified in (c)(5), we are adopting a position that providers attest that information contained in the information collection instrument is correct to the best of their knowledge and belief.

Consistent with EMTALA regulations, under this statute, the provider will be required to document the patient's file regarding the patient's eligibility when the patient is a member of a group for which payment under section 1011 is possible. While we expect that hospital staff and other providers will routinely collect and maintain patient eligibility information when it is determined that a section 1011 payment may be applicable, we are adopting a position that hospitals and other providers are not required to maintain patient eligibility information for individuals where a section 1011 payment is not possible.

We are adopting a position that providers maintain patient eligibility information and that patient eligibility information will not routinely be submitted to CMS. While some individuals have suggested that patient eligibility information be sent to one central location, we do not believe that collecting this information is necessary given the payment methodology we are adopting. In addition, we are concerned about the

paperwork burden and administrative expense associated with sending patient eligibility data to CMS on a regular basis.

As noted above, while hospitals and other providers will be required to collect information regarding individuals' eligibility status in order to assure that section 1011 funds are being spent appropriately, we are adopting a position that providers are not required to submit this information to CMS as part of routine claims processing. However, providers are required to maintain this patient eligibility information for purposes of audit or compliance review. Moreover, since hospitals are in the best position to request information regarding a patient's eligibility status after meeting EMTALA requirements, we would require that hospitals maintain eligibility information for patients for whom section 1011 payment would be sought and that hospitals would make this information available to physicians and ambulance providers. Thus, the hospital eligibility determination would also apply to "related" ambulance and physician services as well.

If a hospital chooses not to participate in the section 1011 program or does not collect the patient eligibility information, a physician or ambulance provider is required to collect and maintain patient-specific eligibility information before billing the section 1011 program.

In conclusion, 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).

X. Payment Methodology

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). The statute also requires the Secretary to make a pro-rata reduction (see section XIV, 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.

While the statute would allow CMS to design a prospective payment approach for section 1011, we are not implementing 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 adopting a retrospective payment approach. 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 payment methodology.

Given that CMS is establishing a retrospective payment methodology, another issue that must be resolved to implement section 1011 is the question of what type of

retrospective payment methodology should CMS use in paying providers for care provided to undocumented aliens and certain other aliens.

Other Options Considered

We previously considered establishing a service-based payment methodology with aggregate quarterly summaries. Under this option, CMS would have required 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. 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 have been 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.

In general, 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., physician only emergency department service), it would result in overpaying some providers for particular services.

Finally, we considered establishing a payment methodology based on a statistical 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: (1) does not allow a provider to demonstrate the actual cost incurred for rendering EMTALA-related services, (2) does not link payment to a specific patient, and (3) 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 could 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 an appropriate payment 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. We detail the payment methodologies we will use in section XIII of this paper.

Final Implementation Approach -- Payment Methodology:

We are adopting a bill-specific payment methodology. CMS will 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 will be determined based on the information included in these claims. We believe that this system establishes an efficient payment process for providers. In establishing our payment methodology, we are generally using Medicare payment rules to calculate the payment amount for hospital services up to the point of stabilization, 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 determined based on the same methodology use by Medicare to pay those facilities.

This approach would establish a fair and consistent approach to provider reimbursement for the costs each provider incurs for treating and stabilizing undocumented and certain other 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 lesser of its costs**,** the Medicare reimbursement rate or, if provider payments exceed the state allotment, a proportional payment of the Medicare reimbursement rate. Thus, if a pro-rata reduction were applicable, then CMS would apply a common discounting factor to each Medicare based payment rate 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 payment determination approach would allow CMS 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 ensure that inappropriate, excessive or fraudulent payments are not made.

XI. Distribution of State Funding to Providers

In our initial proposal, we considered establishing a single provider funding pool in each state.

Public Comments

Several commenters recommended that we distribute funding according to specific funding allocations for each provider type. One commenter recommended that we use the national or state Medicaid payment data to establish distinct funding pools for each provider. Another commenter recommended that state allocation be distributed according to a defined methodology. Using the commenter's methodology, hospitals and physicians would each receive 49 percent of the state allocation with ambulance providers receiving the remaining 2 percent of the state allocation.

While we appreciate and understand the rationale for establishing distinct funding pools, we do not favor this approach because it unnecessarily limits provider payment 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.

Final Implementation Approach – Creation of State Funding Pool

As we have stated above, state allotments are based on the statutory formula. Using the final state allotments, we are adopting a policy that establishes a single provider funding pool in each state and the District of Columbia. This approach would establish a single payment allocation per state and each provider would receive a payment from the state allocation. We believe that this approach would maximize provider payment, 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.

XII. Submission of Payment Request

CMS requires that providers requesting reimbursement for aliens described in paragraph (c)(5) of section 1011 submit claims within 180 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. 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.

Providers should submit individual claim submissions for services rendered on or after May 10, 2005. This approach provides for appropriate payment to providers of health care services required by the application of section 1867 and related hospital and outpatient services and ambulance services for individuals identified in (c)(5) of section 1011.

Basic Requirements for all Section 1011 Claims:

We are adopting a position that section 1011 claims meet the following requirements:

1. We are adopting a position that a claim must be filed electronically with CMS' designated contractor in a form prescribed by CMS in accordance with CMS' Medicare processing instructions. For the purposes of section 1011, CMS will require that a hospital submit an electronic claim that complies with the X12N 837 version 410A1 institutional claim implementation guide (the electronic equivalent of the UB-92) and that physicians and non-hospital ambulance providers submit an electronic claim that complies with the X12N 837 version 410A1 professional claim implementation guide (the electronic equivalent of the CMS-1500).

We are adopting a position that hospitals electing to receive payments for hospital and physician services under (c)(3)(C)(i) of section 1011 must submit separate bills for hospital and physician services.

2. We are adopting a position that a claim must have a date of service on or after May 10, 2005. For the purpose of section 1011 payment, services rendered prior to May 10, 2005 or initiated on or before the May 9, 2005 are not eligible for payment.

3. We are adopting a position that providers must file an electronic claim within 180 days of the end of the federal fiscal quarter in which the service was provided**.** Accordingly, if services are rendered on May 12, 2005, a provider must submit a payment request no later than 180 days from the end of that fiscal quarter (i.e., June 30, 2005) in order to receive payment. 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.

4. We are adopting a position that a hospital's request for on-call payment must have a date of service on or after May 10, 2005. For the purpose of section 1011 payment, hospital on-call payments made by the hospital for physician services on or before May 9, 2005 are not eligible for payment.

Submission of Medical and other Documentation

Unless specifically requested, CMS is adopting a position that hospitals and other providers maintain, but not submit, medical and/or patient eligibility information for payment purposes. CMS' designated contractor may review claims documentation prior to making a section 1011 payment. Moreover, the compliance review contractor may

review claims documentation during the compliance review process to determine the accuracy of payments.

Designated Claims Processing Contractor

CMS will designate a single contractor for the purposes of enrolling providers, 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. We expect to award the contract for the designated contractor shortly.

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

Designated Compliance Contractor(s)

CMS is a adopting a position that a compliance contractor will review medical and non-medical documentation. The compliance contractor may conduct pre-payment or post-payment claim reviews, identify and assess overpayments, if necessary, and ensure compliance with the provisions outlined in this notice.

XIII. Determination of Payment Amounts

As stated above in section X, Payment Methodology, we generally 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, section (c)(2)(A) requires that CMS 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 the transfer payment policy under the Inpatient Prospective Payment System (IPPS) for acute care hospitals, specifically payments will be calculated as if the patient were transferred on the day of stabilization or the appropriate excluded payment system for inpatient hospital services (including pre-

admission bundling and all other payment rules.) In this way, payments will more appropriately track resource use regardless of the time it takes to stabilize a patient;

- payment rules using the transfer payment policy under the IPPS for long term care hospitals (LTCHs), which are acute care hospitals, because we are considering only the time until stabilization, which will generally be significantly shorter than the long stays usually associated with LTCHs;

- payment rules using the inpatient psychiatric hospital PPS for inpatient psychiatric hospitals transitioning to the inpatient psychiatric hospital PPS to calculate what Medicare would have paid on a per diem basis for the days up to and including the date of stabilization;

- payment rules using the transfer payment policy under the inpatient rehabilitation facility prospective payment system;

- the interim payment on the bill for inpatient services provided by critical access hospitals (a per diem amount for routine services and a percentage of billed charges for ancillaries); and,

- the TEFRA per discharge limit for children's and cancer hospitals excluded from the IPPS.

- payment rules under the Outpatient Prospective Payment System (OPPS) for hospital outpatient department EMTALA and EMTALA-related services not associated with an inpatient admission.

- payment rules under the physician fee schedule for Medicare participating physicians (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). Similarly, we are adopting a position to pay physicians not enrolled in Medicare the PFS payment amount.

- payment rules under the ambulance fee schedule for ambulance trips that would be separately payable under the Medicare program if the patient were a Medicare beneficiary. Consistent with Medicare policy, the point of pickup determines the basis for payment under the fee schedule and the point of pickup is reported by its five-digit zip code. Thus, the point of pickup zip code determines the both level of payment under fee schedule and applicable geographic practice costs index (GPCI). If a second ambulance transport is required for a subsequent transport, then the zip code of the point of pickup of the second or subsequent transport determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg.

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

Determination of Hospital On-Call Payments

CMS has determined that hospitals electing to receive payments under section (c)(3)(C)(ii) will receive a percentage of the on-call payments made by the hospital to physicians. Hospitals electing to receive payments under section (c)(3)(C)(ii) will be required to submit a payment request to claim on-call costs.

CMS requires that hospitals must file the hospital on-call information collection instrument within 180 days of the end of the federal fiscal quarter to claim payment. Failure to submit the hospital on-call information collection instrument within the prescribed time frames will result in the payment denial for on-call costs. This requirement is necessary given that section (c)(3)(D) of section 1011 requires that the Secretary make quarterly payments to eligible providers.

On May 9, 2005, the OMB approved the Request for Section 1011 Hospital On-Call Payments to Physicians information collection instrument and related instructions. The hospital on-call payment form can be found at http://www.cms.hhs.gov/providers/section1011.

Determination of Payments for Undocumented Uncompensated Care

Hospitals that are unable to make an affirmative decision regarding a patient's eligibility may not receive the full amount of their uncompensated care for individuals identified in (c)(5) of section 1011. Since we recognize that some patients may refuse to provide hospital staff or other providers with the necessary information to make an

affirmative section 1011 eligibility determination, we have adopted an approach which would allow hospitals and physicians to receive a fraction of the outpatient emergency department care costs for individuals who refuse to provide information regarding their eligibility or provide the necessary billing information (e.g., valid address) that prevents the hospital from collecting payment from the patient.

Because we presume that one in every 10 people that a hospital would treat, who would otherwise be an alien described under section 1011(c)(5), will refuse or be unable to furnish the required eligibility information, we are going to create an additional payment to providers who furnish services (based on appropriate funding methodology discussed above) in the amount of 10 percent of the total approved outpatient services furnished in a quarter, subject to the pro-rata reduction. This increase in payment is intended to provide compensation to hospitals and physicians for services rendered in an outpatient setting for those patients who refuse to or unable to provide an affirmative demonstration of their eligibility status. We are also adopting a position that ambulance provider approved claims will be increased by 10 percent for those patients who refuse to or unable to provide an affirmative demonstration of their eligibility status.

XIV. Pro-Rata Reduction

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 quarter within a state are $40 million, but the state quarterly allotment is set at $5 million, then each provider would receive 12.5 percent of their approved payment 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 determine whether the pro-rata reduction would be applicable for a given quarter or state until we receive actual claim submissions. It is also important to note that the pro-rata reduction will vary from quarter to quarter and from state to state.

XV. Quarterly Payments

CMS is adopting a quarterly proportional payment approach. Under this approach, CMS would make proportional provider payments on a quarterly basis but would not attempt to adjust provider payments within a state on an annual basis. In determining the quarterly state funding allotment, the annual state allotment will be divided by four and distributed on a quarterly basis. In selecting this approach, we believe that providers would like to receive the maximum payment available within the shortest time period.

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 are adopting a position to begin to make quarterly payments beginning two to three months after the claims filing deadline. Providers will receive quarterly payments approximately every three months thereafter.

Implementation Approach for FY 2005

For services rendered in FY 2005, CMS is adopting a policy to issue two proportional, rather than four, payments for the third and fourth quarters of FY 2005. Because we believe emergency services will in general be provided throughout the year, and because we believe the pro-rata reduction will likely be applied, we believe that basing FY 2005 payments on the last 2 quarters will still accurately reflect providers' costs of treating eligible patients.

Because these instructions regarding information collection were not available to eligible providers in advance of April 1, we will adjust claims for the third quarter of fiscal year 2005 (April 1, 2005 – June 30, 2005) by developing for each hospital, physician and ambulance provider or supplier an average claimed amount per day for the period for which the instructions were available, and then multiplying that by the number of days in the quarter. In this way, we will adjust the claimed amount to cover the services of the entire quarter, rather than only the period for which the instructions are available.

For example, if CMS published this notice on May 9, and a provider submitted approved claims totaling $50,000 for services provided from May 10-June 30, a period of 52 days, the average daily claimed amount for the period would be ($50,000 / 52 days) = $961.54 per day. Because there are 91 days in the quarter, the claimed amount for the entire quarter would then be calculated as ($961.54 per day x 91 days), or $87,500.14.

Implementation Approach for FY 2006 and Beyond

In FY 2006 and beyond, CMS will issue four proportional payments.

XVI. Appeals and Claim Adjustments

While we are not adopting a formal appeals process, we believe that providers should have an avenue to address payment disputes. Accordingly, we are adopting an informal appeals process to resolve payment disputes. In order to ensure timely and accurate payments to all providers, an informal appeals process will allow providers an opportunity to seek clarification of payment decisions while significantly reducing the time that it takes to resolve payment disputes.

Since it is essential that we ensure administrative finality, we believe that this approach is consistent with section (c)(2)(B) of section 1011. Moreover, given the expected level of reimbursement for these payments, it does not seem cost effective for providers or CMS to establish a formal appeals process.

The designated contractor will provide additional information regarding the informal appeals process during the claiming process.

Claims Adjustments

To simplify the administration of this provision, we are adopting the position that providers are not allowed to submit a claim adjustment.

XVII. Compliance Reviews

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.

To ensure that claim submissions are supported by clinical and non-clinical documentation, we are adopting a position of compliance reviews. These reviews may be based on, among other things, identified aberrancies and claims volume.

XVIII. Overpayments

We are adopting a position that each provider participating in the section 1011 project agree to repay any assessed overpayment. To simplify the administration of this program, CMS is adopting a position to withhold any identified provider overpayments from the next quarterly section 1011 payment. CMS will notify the provider and withhold payment from the quarterly payment until the overpayment is repaid.

In the event that a provider does not have a sufficient balance in the next quarterly payment to repay the overpayment in full, then CMS will then notify the provider that the provider has 30 days to repay the overpayment without accrual of interest. Upon notification that an overpayment exists, the provider that fails to repay the overpayment within 30 days will accrue and be responsible for any interest determined to be applicable. Moreover, we are adopting a position to refer unpaid overpayments to an appropriate debt collection agency or the Department of Treasury consistent with the requirements of the Debt Collection Improvement Act.

XIX. Annual Reconciliation Process

We are adopting a position to conduct a reconciliation process for each state annually. It is during this process that we 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 any overpayments, whether withheld or refunded by a provider, will be redistributed. Thus, we are adopting a position that all overpayment will be redistributed during the annual reconciliation process. In the event that overpayments are assessed during a compliance review process, but repaid subsequent to the annual reconciliation process, we will redistribute these funds during a future annual reconciliation process.

XX. Unused State Funding

In our initial proposal, we stated that any unobligated state funds would not be available for redistribution to another state and that 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.

Public Comments

A number of commenters stated that unused state allocations should be reallocated to other states or rolled over to the state allocation for the next year. While we do not have the authority to reallocate unused state allocations from one state to another, we agree with the commenters recommendation that we roll over unused state funding from one fiscal year to the next. Thus, if State A has an allocation of $1 million in FY 2005, but providers in State A are paid $750,000 in FY 2005, the remaining $250,000 will be added to the available state funding allotment in FY 2006.

Final Implementation Approach

Congress expressly states that the appropriation shall remain available until expended. In doing so, Congress has removed all statutory time limits as to when the funds may be obligated and expended. In essence, the funds remain available for obligation for authorized purposes until fully obligated within the purposes and limitations attributable to that appropriation.

We believe that the statute clearly indicates that the purpose of the appropriation is to make payments to providers within a state subject to the amounts available under the allotment made to the state. Once appropriated, the funds become available until expended, with no fiscal year limitations on their availability for expenditure. In the event that all of the funds allotted to a state in a fiscal year are not used to make payments to providers in that state, we are adopting a position that these unexpended funds continue to remain available for provider payments within that state in subsequent fiscal years.

There is no indication in the language of the law that state allotments could be redistributed to another states or that the funds could be returned to CMS for other uses. Thus, CMS is adopting a position that a state allocation cannot be redistributed from one jurisdiction (state or the District of Columbia) to another jurisdiction.

Date:_____ _____

Michelle Shortt

Acting Director

Regulations Development Group

Office of Strategic Operations and Regulatory Affairs