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August 16, 2004

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

Re: *Section 1011 of the Medicare Prescription Drug, Improvement and
Modernization Act of 2003- Documentation of Citizenship Status*

Dear Mr. Bossenmeyer:

The National Immigration Law Center (NILC) welcomes the opportunity to provide comments on the proposed policy paper on the implementation of Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("Section 1011") released by CMS on July 21, 2004 (the "Policy Paper"). NILC is a nonprofit legal services organization that works on behalf of low-income immigrants and their families, with a special focus on access to health care services and public benefits. Our comments relate primarily to the section of the Policy Paper titled "Documentation of Citizenship Status"

A fundamental premise underlying our comments is that individual and public health are harmed when immigrant families are deterred from seeking needed health care because of questions about their immigration status. Based upon that premise, we have previously urged CMS to use a data-based "proxy" methodology to allocate Section 1011 funds to providers, without requiring questions about individuals' immigration status. We urge CMS to reconsider its rejection of that methodology.

The Policy Paper proposes the use of an individual patient based documentation approach to allocate Section 1011 reimbursement funds among providers. The proposed process requires providers to query individual patients about their immigration status and to record and retain this information. The Policy Paper suggests, erroneously, that undocumented status can be inferred from patients' possession of various forms of foreign-issued or "faulty" identification, and requires providers to collect evidence of such possession. In order to avoid employing discriminatory criteria in selecting patients to be questioned about their status, providers would have to collect this information from all emergency patients. In addition, it would place a significant administrative burden on the stressed emergency health care system and increase dangerous delay in the provision of emergency health care services.

Moreover, **asking individuals to declare or somehow prove their "undocumented" status will cause them to avoid seeking needed health care for themselves and their family members, with severe consequences for individual and public health.** Our organization often hears reports of immigrant families who avoid needed health care because of fears that undocumented family members will be reported to the Department of Homeland Security. Chicago-based health advocates report an incident that occurred during the recent Fourth of July holiday. Witnesses reported that a woman and two children were shot in a park, but only one child appeared at the hospital seeking care.

Advocates held a press conference to encourage the other victims to go to the hospital, after learning that the victims were afraid to seek medical treatment because of fears that they would be reported to immigration authorities.

Respondents to the California Immigrant Welfare Collaborative's 2003 immigrant health care survey reported numerous cases of clients who avoided seeking health care because of fears related to a family member's immigration status. The consequences of such deterrence included complications from untreated asthma, diabetes and hypertension, serious untreated vision problems, such as a child's glaucoma, cancers that progressed while untreated, and a child who suffered a burst appendix. In one case, a child's untreated strep throat progressed into a heart condition. This child's case illustrates the public health risks of deterring families with undocumented members from seeking health care. It is unknown how many other classmates and other individuals were infected after exposure to this child.

HHS has recognized that public health is harmed when immigrants avoid seeking needed health care. As reported by the Department of Justice in the preamble to its proposed public charge regulations, "Federal and State benefit granting agencies" had reported that immigrants' concerns about using health services were creating "significant negative public health consequences across the country." The preamble states:

This situation is becoming particularly acute with respect to the provision of emergency and other medical assistance, children's immunizations, and basic nutrition programs, as well as the treatment of communicable diseases. Immigrants' fears of obtaining these necessary medical and other benefits are not only causing them considerable harm, but are also jeopardizing the general public. 64 Fed. Reg. 28676 (May 26, 1999).

Citizens, as well as immigrants, will miss out on essential health services if undocumented persons are afraid to interact with health care providers. Children will bear this burden the hardest. According to the Urban Institute, 85% of immigrant households include at least one U.S. citizen, typically a child. (Michael Fix, Wendy Zimmermann and Jeffrey S. Passel, *Integration of Immigrant Families In the United States*, Urban Institute, (July 2001). The UCLA Center for Health Policy Research 2001 California Health Interview Survey (CHIS) found 650,000 U.S. citizen children with at least one undocumented parent in California, representing 44% of California children under age 6 and 39% of children ages 6 through 11. If immigrant parents are afraid to interact with health care providers, their citizen children will also be denied health care.

While we appreciate that CMS acknowledged the risk of this deterrent effect in the proposed Policy Paper, we believe that the process proposed in the paper disregards it. **We continue to encourage CMS to utilize a data-based 'proxy' methodology for allocating provider reimbursements.**

The Medicaid Application Process

CMS has pointed to the fact that providers assist immigrant patients in preparing Medicaid applications, which require immigration status information, in dismissing claims that its proposed methodology will burden providers and deter patients from seeking treatment. This justification misses the mark in several respects:

- An individual decides whether to apply for Medicaid. If an individual does not want to provide personal information for governmental use, there is no requirement that he or she provide any of the information required to complete a Medicaid application. In contrast, nondiscriminatory implementation of the Policy Paper's recommendations would require that all emergency patients (or all uninsured emergency patients, at facilities that choose to forgo balance billing) be questioned about their immigration status.

- Medicaid is only available to individuals who are ‘categorically eligible,’ in addition to meeting the financial eligibility requirements. Hospital financial services staff are sufficiently knowledgeable to avoid commencing a Medicaid application on behalf of a person who has no claim to categorical eligibility, such as a childless, non-disabled adult. In contrast, the nondiscriminatory implementation of the process outlined in the Policy Paper would require providers to gather information on all emergency patients.
- CMS asserts that “An applicant for Medicaid must declare by signing a declaration whether he or she is a citizen or national of the United States or an alien in satisfactory immigration status.” (Policy Paper p.16). This claim is true with respect to the “full-scope” Medicaid program, for which citizenship or qualified alien status is a condition of eligibility. Persons who do not meet the immigration status requirements, but who are otherwise eligible for Medicaid, are eligible to receive “emergency Medicaid” for emergency medical conditions only. 42 USC §1396b(v)(2). Such persons include both undocumented immigrants and persons who are lawfully present but not eligible for full scope Medicaid, such as qualified immigrants subject to the five year bar imposed by 8 USC §1613.
- As CMS asserts, all Medicaid applications ask whether the applicant is a U.S. Citizen. Undocumented persons applying for emergency Medicaid are only required to assert that they are not U.S. Citizens. They are not required to state that they are undocumented, and are *never* required to produce documentation to demonstrate undocumented status. Applicants for emergency Medicaid are exempted by statute from providing verification of their immigration status. 42 USC §1320b-7(f).¹ The implication, on Attachment B, that undocumented patients should state, or somehow demonstrate, their status, is an intimidating new requirement for this population.

The information collection process described in the CMS Policy Paper affects far more patients and involves a broader scope of information than is collected through the Medicaid application process. CMS’ proposed process is more far burdensome for providers and intimidating for patients than the current Medicaid application process.

Information Collection Instrument

While reiterating that we oppose any individual determination of patients’ immigration status in calculating providers’ eligibility for Section 1011 reimbursement, we are compelled to provide specific comments on the Information Collection Instrument appended to the Policy Paper as Attachment B.

No one should be subjected the fear of being deported and leaving behind family, friends and community as a condition of receiving emergency health care. **Under no circumstances should emergency patients be required or encouraged to identify themselves as undocumented, as is suggested by question 8a on Attachment B.** Similarly, presenting false documents can be a criminal offense. **Individuals should never be encouraged to present fraudulent identification or documentation, as is suggested in question 8c.**

As a technical matter, we note that a foreign born individual’s possession of the documents listed in question 8b would only identify that person as having lived in a foreign country, and would not

¹ CMS acknowledges this exception on page 16 of the Policy Paper.

serve as an accurate measure of undocumented status. Likewise, the factors listed in 8c fall short of demonstrating an individual's immigration status. We further question whether health care providers would have the capacity to identify a "faulty" social security number or driver's license.

A better approach to determining status would be to ask the individual a series of questions, such as:

"Are you a citizen," "Are you a lawful permanent resident (do you have a green card)?"
"Are you a refugee or other person who was admitted into the country because you were fleeing persecution?" "Do you have a visa?" "Do you have work authorization?"²

If a person has not answered yes to any question, a reasonable inference can be drawn that they are not lawfully present and that their expenses can be submitted for reimbursement.

Patient Confidentiality

Our concerns about the proposal are heightened by the absence of any restrictions on the misuse or sharing of the information collected through CMS' proposed process. In fact, CMS' process assumes that hospitals will share information they collect with physicians and emergency transportation providers. Even citizens have good cause to be concerned that, under the process CMS proposes, their names, contact information and social security numbers will be collected, maintained and shared without restrictions.

At minimum, the information should not be recorded and maintained with the individual's name and contact information. Providers could assign a unique identifier, such as a dummy medical record number, to the information required for reimbursement in order to protect the privacy of the patient. In addition, CMS should clarify that the information should not be shared for any purpose not directly related to claiming Section 1011 reimbursement, and impose penalties on providers who violate this restriction.

In summary, we urge CMS to reject the individual claims-based approach it proposes and to adopt instead a statistical proxy-based methodology for estimating the portion of providers' uncompensated costs that are reimbursable with Section 1011 funds.

We appreciate the opportunity to submit these comments and hope to work with CMS in the implementation of an improved procedure. Please contact Gabrielle Lessard, (213) 639-3900 x 114, if we can provide any additional information.

Respectfully submitted,

Gabrielle Lessard
Staff Attorney

² This series of questions is provided as an example. If CMS elects to use this option, NILC is available to work with CMS in developing an instrument.