CMS Backs Off Proposal that Would Have Required Hospitals to Ask Emergency Patients about Their Immigration Status

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Section 1011 of the recently enacted Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Act) appropriated $1 billion for payments to hospitals that furnish emergency health services to undocumented aliens. On July 21, 2004, the Centers for Medicare & Medicaid Services (CMS) proposed to implement this section of the Act by requiring hospitals that wish to request payments under the Act to ask patients about their immigration status and document their responses. Following CMS’ proposal, hospitals across the country scrambled to identify ways to incorporate CMS’ proposal while steering clear of activities prohibited under Title VI of the Civil Rights Act of 1964 and the federal Emergency Medical Treatment and Active Labor Act, as well as analogous state laws. However, CMS reportedly backed off its proposal in a letter to the National Alliance for Hispanic Health dated October 1, 2004, the day the proposal was to have taken effect.

For years, state officials and hospital executives have argued that the federal government should cover the costs associated with providing health care to illegal

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immigrants, which weigh heavily on border states such as Texas, Arizona, and California. According to the former U.S. Immigration and Naturalization Service (INS), an estimated seven million undocumented aliens resided in the United States (and more than one million resided in Texas) in the year 2000.\(^3\) Texas hospitals located near the U.S.-Mexico border spend significant financial and medical resources providing emergency and other health care services to undocumented aliens.

In a May 2004 report by the United States General Accounting Office (GAO), the GAO attempted to address the impact of undocumented aliens on hospitals’ uncompensated care costs.\(^4\) As part of its research, the GAO surveyed 503 hospitals, interviewed Medicaid and hospital officials in ten states (including Arizona, California, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, North Carolina, and Texas), and interviewed and obtained data from Homeland Security officials.\(^5\) However, the GAO was unable to assess the impact of undocumented aliens on hospitals’ uncompensated care costs in part because the GAO found that most hospitals do not collect information relating to their patients’ immigration status.\(^6\)

Historically, the federal government has made some funds available directly and indirectly to help cover the costs associated with providing health care to undocumented aliens.\(^7\) Under the new Act, two-thirds of the funds will be divided among all fifty states


\(^{4}\) Id.

\(^{5}\) Id. at 2.

\(^{6}\) Id. at 3.

\(^{7}\) Medicaid provides some coverage for treatment of emergency medical conditions for some aliens who are eligible for Medicaid and choose to enroll in it. See 42 U.S.C. § 1396b(v)(2)(A); 42 C.F.R. § 440.255(b)(1). In addition, Medicaid disproportionate share hospital adjustments provide supplemental payments to some hospitals that serve relatively large numbers of low-income patients, which can include undocumented aliens. GAO REPORT, supra note 3, at 3. Moreover, the Balanced Budget Act of 1997
and the District of Columbia using INS data, which establishes the relative percentages of undocumented aliens in each jurisdiction.\(^8\) The remaining one-third of the funds will be divided among the six states with the largest number of undocumented alien apprehensions. The preliminary allocation for Texas is $47,508,379 ($24,824,647 for undocumented aliens and $22,683,733 for alien apprehensions). Under the Act, the Secretary of the Department of Health and Human Services had until September 1, 2004, to establish a process for hospitals and other health care providers to request these payments.

Accordingly, on July 21, 2004, CMS published a proposed process for hospitals and other providers to request payments under the Act.\(^9\) In its proposal, CMS stated that hospitals and other health care providers who request payments under the Act would be required to collect and maintain additional information regarding the immigration status of patients. CMS specifically proposed to adopt a “patient based documentation approach” pursuant to which providers will be required to document the patient’s citizenship status and whether the patient is a member of a group for which payment under section 1011 of the Act is possible. In documenting citizenship status, CMS proposed that providers use a Medicaid enrollment application or another existing information collection instrument that requires the applicant to make a declaration regarding citizenship or immigration status. As an alternative to using the Medicaid enrollment application process or another established information collection instrument, CMS included in its proposal a form specifically designed to obtain necessary

\(^8\) Id. at 24. According to 2000 INS data, approximately 14.9% (or 1,041,000) of the undocumented aliens residing in the United States live in Texas. \(Id.\)

\(^9\) CMS PROPOSAL, supra note 1.
information regarding a patient’s citizenship. CMS’s information “collection instrument” contained questions such as: (1) Are you a United States Citizen? (2) Are you a lawful permanent resident, an alien with a valid and current I-688B, or other qualified alien? (3) Are you in the United States on a non-immigrant VISA? (4) Are you a foreign citizen that has been admitted to the U.S. with a 72-hour border crossing card? (5) Have you been paroled into the United States for the purposes of receiving eligible services and do you have a Form I-94? (6) Do you have a Social Security Number or health insurance policy number? Mark B. McClellan, Administrator of CMS, stated his belief that hospitals could ask these questions in “an unobtrusive way” that would not discourage immigrants from seeking care.

CMS’ proposal caused hospitals across the United States to scramble to identify ways to ask their uninsured emergency patients these questions in light of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, or national origin in any program or activity operated by entities such as Medicare participating hospitals that receive federal funds or other federal financial assistance. Title VI has been interpreted to mean:

... in operating or participating in a federally assisted program, a provider should not, on the basis of race, color or national origin, directly or indirectly differentiate among persons in the types of program services, aids or benefits it provides or the manner in which it provides them. For example, providers should treat all similarly situated individuals in the same manner, and should not single out individuals who look or sound foreign for closer scrutiny or require them to provide additional documentation of citizenship or immigration status.

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10 Id. at 31 (Attachment B).
13 CMS PROPOSAL, supra note 1, at 16.
Medicare participating hospitals also scrambled to identify ways to ask citizenship questions and obtain the required documentation in light of the federal Emergency Medical Treatment and Active Labor Act (EMTALA), which prohibits hospitals from delaying screening examinations and stabilizing treatment to inquire about method of payment or insurance status.\textsuperscript{14} In its proposal, CMS advised hospitals to request information about a patient’s citizenship or immigration status “prior to discharge, but after the patient is identified as self-pay and not Medicaid eligible.”\textsuperscript{15} CMS further emphasized that providers should not delay screening or treatment in order to inquire about citizenship.\textsuperscript{16}

Although hospitals collect a variety of demographic and clinical information from their patients, hospitals generally do not ask patients about their immigration status. Accordingly, CMS’ July 2004 proposal was alarming to many hospital administrators, who believed that the citizenship documentation process would cost them more than they will receive in financial aid, as well as immigration advocates, who believed that the process would deter undocumented aliens from seeking emergency care when they really need it.\textsuperscript{17} Immigration experts believed that the technical questions designed to determine immigration status would “befuddle” both hospital employees and immigrants.\textsuperscript{18} In addition, civil rights group speculated that undocumented aliens would fear that their answers would be used against them in deportation proceedings.\textsuperscript{19} Marcela G. Urrutia, an analyst at the National Council of La Reza, a Hispanic civil rights group,

\begin{footnotes}
\item[14] 42 U.S.C. § 1395dd(h).
\item[15] CMS PROPOSAL, supra note 1, at 17.
\item[16] Id.
\item[17] Pear, supra note 11, at A1.
\item[18] Id.
\item[19] Id.
\end{footnotes}
stated: “We are extremely concerned about this requirement. It will deter Latino communities from seeking emergency care. That could lead to serious public health problems, including the spread of communicable diseases.” Similarly, Janelle Howard, a spokeswoman for Carondelet Health Network, stated: “Our emergency rooms see a lot of undocumented immigrants . . . But as a Catholic institution, we have never asked about their immigration status. It’s our mission and philosophy to treat all without distinction.”

Reports of an October 1, 2004, letter from Mark B. McClellan, CMS Administrator, to the National Alliance for Hispanic Health allayed the fears of many of these hospital administrators, immigration experts, and civil rights groups. In his letter, McClellan stated that CMS would use “indirect, non-burdensome eligibility methods” to determine payments to hospitals that furnish emergency health services to undocumented aliens. McClellan further stated that, “Providers will not be asked—and should not ask—about a patient’s citizenship status in order to receive payment under this program.”

CMS’ new position is not without its critics. Representative Dana Rohrabacher (R-Calif.), who fought to require hospitals to collect information on undocumented patients and make it available to law enforcement officials, stated: “Who’s watching out for the American people? This is incredible. You’ve got hospitals watching out for the illegal immigrants and the administration going along with it.” Similarly, Mark Krikorian of the Center for Immigration Studies, which favors tighter immigration

20 Id.
21 See Letter, supra note 2.
22 Gonzalez and Bustos, Hospitals Not Required to Ask about Citizenship, supra note 2.
23 Sheridan, Hospitals Won’t Have to Ask About Immigration Status, supra note 2, at B01.
24 Id.
enforcement, argued that, “The real solution is stopping illegal immigration—not letting it happen, then trying to clean up the mess afterwards.”

25 Id.