Supporting Statement

Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, Section 1011 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA): "Section 1011 Provider Payment Determination" and "Request for Section 1011 Hospital On-Call Payments to Physicians" Forms

A. 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 passed these antidumping provisions 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 of the MMA provides $250 million per year, allocated by state, for fiscal years (FY) 2005 through 2008, for payments to eligible providers for emergency health services provided to undocumented and other specified aliens. From the respective state allotments, payments are made directly to enrolled hospitals, 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 include Indian Health Service facilities whether operated by the Indian Health Service or by an Indian tribe or tribal organization, and Medicare critical access hospitals. Payments under Section 1011 may only be made to the extent that care was not otherwise reimbursed (through insurance or otherwise) for such services.

Payments are 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 port of entry for the purpose of receiving eligible services; and 3) Mexican citizens permitted to enter the United States 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.

B. Justification

1. Need and Legal Basis

   Section 1011 of the MMA requires that the Secretary establish a process under which eligible providers (certain hospitals, physicians and ambulance providers) may request payment for (claim) their otherwise un-reimbursed costs of providing eligible services. The Secretary must make quarterly payments directly to such providers. The Secretary must also implement measures to ensure that inappropriate, excessive, or fraudulent payments are not made under Section 1011, including certification by providers of the veracity of their requests for payment. The Section 1011 Provider Payment Determination and the Request for Section 1011 Hospital On-Call Payments to Physicians forms have been established to address the statutory requirements outlined above.

2. Information Users

The Centers for Medicare & Medicaid Services (CMS) uses the collected information to administer this health services reimbursement program and establish an audit process.

3. Use of Information Technology

The Section 1011 Provider Payment Determination form is not required to be submitted with the (electronic) claims, however, the information requested on the form is required to be collected and maintained by providers in their preferred format, whether electronic or otherwise. Providers are not required to use the CMS version of the form, and have the option to maintain the information in an electronic format, if preferred. CMS requires providers to maintain HIPAA compliance and abide by all HIPAA privacy and security rules when retrieving, storing, transmitting, transferring or otherwise sharing patient eligibility and other information.

The Request for Section 1011 Hospital On-Call Payments to Physicians form is used by providers to request Section 1011 payment. Because this form is a claim for payment, CMS requires an original signature of the officer or administrator of the provider, therefore this form does not lend itself to electronic collection.

4. Duplication of Similar Information

There is no duplicative information collection instrument or process.

5. Small Businesses

N/A

6. Less Frequent Collection

The information on the Section 1011 Provider Payment Determination form is required to be collected by providers for each claim they make for Section 1011 payment. Less frequent collection of this information would prevent providers from properly documenting individual patient eligibility and, would therefore, make providers ineligible for Section 1011 payment.

The information collected on the Section 1011 Hospital On-Call Payments to Physicians form is required by providers in order to receive payments required under the statute to be made on a quarterly basis. Collecting this information less frequently would prevent CMS from making quarterly payments to providers

as required.

7. Special Circumstances
There are no special circumstances associated with this collection.

8. Federal Register/Outside Consultation
A 60-day Federal Register notice was published on August 15, 2008. In addition, a 30-day Federal Register notice was published on October 24, 2008. No public comments were received from publication of the 60-day or the 30-day Federal Register notices for this ICR.

9. Payments/Gifts to Respondents
N/A

10. Confidentiality
CMS will comply with all privacy and Freedom of Information laws and regulations that apply to this collection.

11. Sensitive Questions
There are no sensitive questions associated with this collection.

12. Burden Estimates (Hours & Wages)

A. Section 1011 Provider Payment Determination Form:
Historical provider payment request (claims) data collected from July 2005 through July 2008 indicate that an average of approximately 12,000 providers complete nearly 300,000 Section 1011 Provider Payment Determination forms each year. CMS expects the number of Provider Payment Determination forms completed and maintained by providers to continue at the same rate.

A random sample of providers surveyed during 2008 indicated that the Section 1011 Provider Payment Determination form takes an average of 11 minutes to complete and is usually completed by clerical patient registration staff. The U.S. Department of Labor, Bureau of Labor Statistics, May 2007 National Industry-Specific Occupational Employment and Wage Estimates for General Medical and Surgical Hospitals indicates that Office and Administrative Support Occupations are paid a mean hourly wage of $14.80. CMS estimates that it takes providers an additional 4 minutes per episode to file

and maintain this form.

The total respondent burden for the Section 1011 Provider Payment Determination form is estimated to be 300,000 provider responses x 15 minutes (74,970 hours) x $14.80 per hour = $1,109,556.

B. Section 1011 Hospital On-Call Payments to Physicians Form: Historical claims data collected from July 2005 through July 2008 indicate that the number of Request for Section 1011 Hospital On-Call Payments to Physicians forms completed by respondents averages less than 148 per year. CMS expects the number of Section 1011 Hospital On-Call Payments to Physicians forms completed and maintained by providers to continue at the same rate.

A random sample of providers surveyed during 2008 indicated that the Section 1011 Hospital On-Call Payments to Physicians form takes an average of 12.5 minutes to complete and is usually completed by a Chief Financial Officer. The U.S. Department of Labor, Bureau of Labor Statistics, May 2007 National Industry-Specific Occupational Employment and Wage Estimates for General Medical and Surgical Hospitals indicates that Chief Executives are paid a mean hourly wage of $79.37. CMS estimates that it takes providers an additional 2.5 minutes per episode to file and maintain this form.

The total respondent burden for the Section 1011 Hospital On-Call Payments to Physicians form is estimated to be 148 provider responses x 15 minutes (37 hours) x $79.37 per hour = $2,935.51.

13. Capital Costs
There are no capital costs associated with this collection.

14. Cost to Federal Government
There are no additional costs to the Federal government. Applications are processed in the normal course of federal duties.

15. Changes to Burden

Section 1011 Provider Payment Determination Form:
The estimated annual responses decreased from 7,500,000

annual responses to 300,000 annual responses, a difference of 7,200,000 annual responses. The Annual Hour Burden decreased from 625,000 hours to 74,970 hours, a difference of 550,030 hours. Changes to burden are due to the use of actual historical program claims data (collected from July 2005 to July 2008) as opposed to using estimates.

Section 1011 Hospital On-Call Payments to Physicians Form: The estimated annual responses decreased from 12,000 annual responses to 148 annual responses, a difference of 11,852 annual responses. The Annual Hour Burden decreased from 9,000 hours to 37 hours, a difference of 8,963 hours. Changes to burden are due to the use of actual historical program claims data (collected from July 2005 to July 2008) as opposed to using estimates.

16. Publication/Tabulation Dates
N/A

17. Expiration Date
We plan to display the expiration date.

18. Certification Statement
There are no exceptions to item 19 of OMB Form 83-I.

C. Collections of Information Employing Statistical Methods

N/A