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Testimony before the House Committee on Government Reform

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"Porous Border and Downstream Costs: The Impact of Illegal Immigration on State, County and Local Governments"

Good morning Mr. Chairman and Members of the Committee. Thank you for the opportunity to participate in this hearing.

The Hospital Association of San Diego and Imperial Counties is a non-profit 501(c)6 trade association that represents hospitals on matters of public policy, legislative advocacy, public advocacy and media relations. We are affiliated with the California Hospital Association and the American Hospital Association.

The hospital delivery system in San Diego is unique to health care delivery in the State for many reasons. One obvious distinction is our geography and proximity to the U.S./Mexico border. Another distinction is that there are no county-owned public hospitals and so private hospitals serve as the safety net for all inpatient, emergency and trauma services for all county residents, regardless of their ability to pay. While this can be attributed to various federal, state and local laws and regulations, contracts and programs, it is also so because local hospitals serve the San Diego community as part of their overarching mission to provide health care to all who require it.

The health care safety net delivery system in San Diego is at capacity and very fragile at this time. A recent and ongoing Healthcare Safety Net Study commissioned by the Board of Supervisors demonstrates that there are great threats to the safety net unless a significant list of challenges posed in the study can be addressed. While these challenges are all formidable, addressing Emergency Department (ED) overcrowding and the access risks the entire community faces if overcrowding is not made a priority issue, is clearly evident.

The causes of Emergency Department overcrowding are all well documented: increased number of uninsured people; increased usage by Medicare and Medicaid beneficiaries who use the ED; workforce shortages, especially nurses and on-call specialists; reduced hospital resources; lack of inpatient beds; and in overall increase in emergency department utilization.

Exacerbating the problem of increased utilization and overcrowding of Emergency Departments is the population of undocumented immigrants, who do not qualify for

emergency Medicaid (Medi-Cal) services. While there is not yet clear data indicating the proportion of immigrants contributing to the overcrowding of EDs, estimates ranging from 5% to 20% of ED visits in the State are attributable to undocumented immigrants.

I have been asked that my testimony respond to four particular areas of concern to the Committee:

- The fiscal Impact of illegal immigration on the health care system in the San Diego area.
- How EMTALA affects health coverage of illegal immigrants in the San Diego area.
- What measure can be taken by the federal and state government to curb the burden of illegal immigration on California's health care system.
- How the recent HHS guidelines on Medicaid eligibility will impact the health care system in San Diego.

The fiscal impact of illegal immigration on the (hospital) health care system in the San Diego area.

The California Office of Statewide Health Planning and Development reports that in 2005 Uncompensated Care (charity care, bad debt) provided by all hospitals in the State was approximately $ 5.5 billion. Of that amount, approximately $ 1.4 billion is attributed to illegal immigrant use. In San Diego County, approximately $476 million in uncompensated care is provided by all local hospitals with approximately $ 119 million attributed to illegal immigrant use.

How EMTALA affects health coverage of illegal immigrants in the San Diego area.

The Emergency Treatment and Labor Act (EMTALA) directs hospitals to provide a medical screening examination to people who present to the emergency department, regardless of their ability to pay or their immigration status, for the purpose of identifying an emergency medical condition. While the objectives of this Act address the core functions and mission of our local hospitals to provide quality care to all patients, the ramification is a burgeoning patient population flow through Emergency Departments and Trauma Centers in San Diego.

Exacerbating this growth in our emergency departments and trauma centers, is the population of immigrants, who do not qualify for emergency Medicaid services. Section 1011 of the Medicare Modernization Act of 2003 targets this population with supplemental resources.

Unfortunately, access to the funding is contingent upon the hospital completing a Provider Payment Determination questionnaire. The process to receive reimbursement is cumbersome and requires additional financial services personnel to manage and

coordinate the implementation of Section 1011. Additionally, hospitals must gather from patients complicated immigration documentation, which is time consuming and rarely forthcoming.

Because CMS believes that the primary purpose of EMTALA services is to "stabilize" the patient on an emergency rather than to cure the underlying illness/injury, under Section 1011, payment will be made for medically necessary emergency services from the individual's arrival at the hospital emergency department until the patient is "stabilized". While patient stabilization is subject to some interpretation and CMS has interpreted it to usually mean treat and release and admission into the hospital, therefore, CMS will not cover the entire patient stay. CMS believes that most patients are stabilized within two calendar days after inpatient admission. The costs of hospitals services provided under Section 1011, should a hospital weather the provider payment determination process, is thus limited with all additional inpatient costs being borne by the hospital.

What measure can be taken by state and federal government to curb the burden of illegal immigration on California's health care system.

Given their mission and current federal law, EMTALA, hospitals will continue to provide patient care for all those who present at their emergency departments, regardless of immigration status or ability to pay. Obviously, enforcement at our borders that curtails illegal entry would curb some of the burden on hospitals.

But important also is that hospitals want to avoid turning healthcare professionals and hospital financial personnel into immigration experts.

The onerous and cumbersome processes that have or will be put in place related to Section 1011 of the Medicare Modernization Act and Section 6036 of the Deficit Reduction Act of 2005 (DRA) distract from hospital operational and support services and could ultimately impact patient care. Hospital personnel must have the ability to focus on providing care rather than worry about immigration status of patients.

While sound public health policy dictates that the health of communities is enhanced by everyone being able to access health care through mechanisms like EMTALA, there is also a need to strengthen broader public health efforts along the border to address the burden not just on hospitals and emergency departments but also the threat of communicable diseases and environmental risks that impact hospitals, clinics and physicians' offices indirectly because of San Diego's proximity to the border.

How the recent HHS guidelines on Medicaid eligibility will impact the health care system in San Diego.

It has been estimated that as many as 35,000 Medi-Cal beneficiaries in San Diego County could be adversely impacted by the recent guidelines because of their inability to provide

acceptable documentation of immigration status. At this time it is still uncertain what the hospitals' staff responsibilities and obligations to discern immigration status will be. The State will publish and disseminate guidelines within the month. However, as mentioned earlier, the process in place under Section 1011 is cumbersome, time consuming and place hospital caregivers in the role of immigration workers.

Notwithstanding this, the exemptions that the Centers for Medicare and Medicaid Services (CMS) have allowed in the rule for seniors and people with disabilities currently receiving Medicare or Supplemental Security Income (SSI) benefits, is welcomed by hospitals. CMS should consider expanding this exemption to include the non-elderly disabled who have severe mental and physical disabilities, the homeless, and anyone receiving Medicaid for five or more years.

For Title IV-E children receiving Medicaid, while not required to declare citizenship for IV-E, must have in their Medicaid file a declaration of citizenship or satisfactory immigration status and documentary evidence of the citizenship or satisfactory immigration status claimed on the declaration. California hospitals encourage CMS to consider an exemption for Title IV-E children on foster care and to children born on Medi-Cal.

The preamble to the regulation states that newborns whose mothers are categorically eligible for Medicaid are deemed eligible and remain eligible for one year as long as the mother remains eligible. Despite this categorical eligibility at birth, these infants will be required to produce citizenship documentation for "re-determination" at their first birthday. In the case of a child born in a U.S. hospital to a mother who is either a legal immigrant subject to the 5-year bar in Medicaid coverage or an undocumented immigrant, the preamble states that, in order for the newborn to continue to be covered by Medicaid, an application must be filed and the citizenship requirements would apply immediately.

We recommend that CMS amend its list of acceptable documents to prove citizenship and identity to include a state Medicaid agency's record of payment for these children. When Medicaid has paid for the birth of a child in a U.S. hospital, the child is by definition a U.S. citizen. Requiring Medicaid agencies to obtain additional documentation is unnecessary and redundant.

The citizenship requirements put forth by CMS will likely translate to increased costs borne by the state, providers and beneficiaries. With respect to services rendered to otherwise eligible beneficiaries, hospitals may in many instances have to forego compensation until and unless the documentation requirements are satisfied. The new requirements will likely result in a potential increase in uncompensated care and would have the added effect of compromising the health status of a significant number of individuals.

The DRA does not require that applicants and beneficiaries submit original or certified copies to satisfy the new citizenship documentation requirement. Yet CMS has added this

as a requirement in the interim final regulations. This requirement serves only to add to the information collection burden of the regulations. To satisfy this requirement, hospitals will ask CMS that States be allowed to accept and use copies of the required documents.

I hope my responses to the areas of you Committee's concern about the impact of illegal immigration on hospitals in the San Diego are helpful to you in addressing House Reform Bill (H.R. 4437) and Senate Reform Bill (S.2611) upon your return to Washington D .C.

Thank you.

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