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POLICY FORUM

Reimbursement of Medical Care for Immigrants

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Physicians who serve large immigrant populations know that it can often be difficult to collect reimbursement for care of patients who are not citizens, due to their economic status, lack of private insurance, or ineligibility for public health coverage. Immigrants generally use substantially fewer health services than the native-born population, but, of course, still need medical care [1]. How can a physician get paid for providing services to this often poor and uninsured population?

There are two main reasons why reimbursement can be difficult. First, some immigrants have less income and less access to private health insurance than native-born Americans. Second, federal law places many restrictions on the eligibility of uninsured immigrants for federally funded programs.

With respect to the first point, fully 45 percent of unnaturalized U.S. residents are uninsured [2]. This problem is multifactorial. Immigrants to the United States tend to be either highly educated (often science PhDs) or poorly educated [3]. Those in the first group are often better paid and more likely to be insured than the native-born population [3], but they are far outnumbered by immigrants who fall into the latter group [3]. While less-educated immigrants are as likely or more likely than native-born Americans to work, they disproportionately work in low-paying jobs in the service sector that usually don't provide health benefits [4]. Accordingly, foreign-born workers, taken as a whole, are significantly less likely to have employer-sponsored private health insurance [5, 6]. And because they also have lower incomes, they're less able to pay for care out-of-pocket.

With respect to the second point, federal law prohibits many immigrants from participating in programs such as the State Children's Health Insurance Program (SCHIP) and other publicly funded programs. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) bars *legal* immigrants—other than a few limited groups such as refugees and asylees—from participating in public benefits including Medicaid for the first 5 years of their residence in the United States [7]. It prohibits sponsored immigrants from participation for at least twice as long, and it excludes undocumented immigrants altogether from participation in nearly all federally funded benefits [8, 9].

There are a handful of exceptions to these rules. PRWORA allows both federal and state funds to be used to provide immunizations and testing and treatment for communicable diseases [10]—services that are often made available by departments

of public health. It also allows federal and state funds to be used for treatment of emergency medical conditions that do not involve organ transplants [11]. This provision is commonly called “Emergency Medicaid.” Congress enacted Emergency Medicaid in part because another federal law, the Emergency Medical Treatment and Active Labor Act (EMTALA), mandates that most hospitals with emergency departments stabilize any patient who presents to the emergency department in active labor or with an immediately dangerous medical condition, regardless of the patient’s ability to pay. It would be particularly problematic if federal law then prohibited emergency medical providers from obtaining reimbursement for that care, merely because of the immigration status of their patient. Finally, under SCHIP regulations, states can receive federal matching funds for prenatal care provided to pregnant women, regardless of the women’s immigration status [12].

PRWORA allows states to choose whether or not to fund benefits for legal immigrants who haven’t yet met federal requirements for assistance and for undocumented immigrants. But states that choose to do so must pay out of their own “pockets.” Twenty-three states presently offer some medical benefits to legal immigrants who are temporarily excluded from federal assistance [13]. If a state or local government wishes to fund benefits for undocumented immigrants, it can only do so if it enacted a law after August 22, 1996 that expressly provides for such eligibility [14].

Accessing public funds for physician services to immigrants who are not part of federal programs can be complex and time consuming. Undocumented immigrants who otherwise *meet Medicaid eligibility requirements* in their state of residence (e.g., on the basis of income, or because they have children, or because they are disabled) and who present with an emergency medical condition may qualify for Emergency Medicaid [15]. Those who qualify for state or locally funded medical assistance programs must apply through the regular channels. Some counties in Texas, for example, have chosen to use their own monies to provide health care to their indigent residents, regardless of immigration status [16]. Physicians are then reimbursed according to the relevant state or local program rules.

Obtaining public funds for physician services to immigrants who *do not* otherwise qualify for assistance is more difficult. To obtain reimbursement for services rendered through 2008, physicians must apply through section 1011 of the Medicare Modernization Act, under which the physician must first establish that no third-party funding other than Emergency Medicaid exists for the specific care in question or that, if it does, the physician has extracted all possible reimbursement from those third parties prior to seeking section 1011 funding [17]. If a balance remains, then Medicare providers must first submit a form CMS-10115 to Trailblazer Health Enterprises, L.L.C., which administers the program for the federal government, within 30 days of the close of the federal fiscal quarter following the quarter for which the reimbursement is being sought [18]. Physicians who are not already Medicare providers must either enroll or file an additional form [18] and then submit Form CMS 10130A 05/05 with supporting documentation to TrailBlazer [19].

The supporting information and documentation are not easy to obtain. Physicians must first determine whether the patient is eligible for or enrolled in Medicaid or Emergency Medicaid [20]. For those patients who are not, physicians must state the reason for the lack of enrollment [20]. They must then determine whether the patient is a foreign national with one of two types of entrance documents [20]. If not, then they must establish that the patient was born in a foreign country and provide one of several forms of supporting documentation [20].

In sum, obtaining reimbursement for care provided to many immigrants who lack private health insurance and cannot afford to pay for their care out-of-pocket can be difficult, and, except in emergency situations, often may not be possible under present law.

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