Chapter 14: Emergency Health Care of Undocumented Persons

Executive Summary

Description

For undocumented persons, federal Medicaid funds may only be used to provide health care services for life threatening emergencies or labor and delivery services for pregnant women. The Sixth Omnibus Budget Reconciliation Act (SOBRA) was enacted by Congress in 1986 to provide a funding stream for these services. In Kansas, eligibility for this program is processed through Social and Rehabilitative Services (SRS) area offices. If the medical event is labor and delivery, the case worker can approve SOBRA eligibility. If the event is not labor and delivery, the provider of the service receives a form to fill out and return with the medical record. The Medicaid fiscal agent, EDS, receives this information and works with the SOBRA program manager to approve or deny eligibility. In 2007, there were 576 requests for non-labor and delivery medical expenses of which 295 were denied. The main challenge in administering this program is consistent application of the federal definition of covered services. Although this is a concern, the quarterly review of SOBRA claims for payment errors shows a current error rate of less than one percent.

In 2007, Kansas SOBRA expenditures for almost 6,000 claims were approximately $10 million. Over $7 million was paid for labor and delivery services with the remainder paid for life threatening emergency services such as tracheotomies, trauma OR, trauma of the brain, and coronary events. The expenditures for FY 09 are estimated to be $10-$12 million.

Key Points

- Because this is a federally mandated program, program options are limited.
- Undocumented individuals have been found to use hospital and emergency services at over twice the rate of the overall U.S. population, according to the National Health Foundation, a not-for-profit foundation comprised of several provider and health plan organizations. Given the large number of undocumented individuals who are uninsured, the high use of emergency services is predictable. By federal law (Emergency Medical Treatment and Active Labor Act – EMTALA), all those who seek services in an emergency room must be screened for needed health care services and stabilized.
- Other health programs exist in the state to assist undocumented persons with their health care needs:
    - The Kansas Department of Health and Environment (KDHE) administers the Migrant Seasonal Farm worker program which provides a state-wide voucher case management sys-

tem through which migratory and seasonal farm workers can receive some types of preventive care through Access Point Agencies.

- KDHE and SRS jointly manage a refugee program that is primarily funded by the U.S. Department of Health and Human Service and supports health screenings of refugees.

Recommendations

- Add a category to the current SOBRA Database maintained by EDS, the Kansas Medicaid fiscal agent, to include the medical issue for each reimbursement form submitted for a life threatening medical emergency.
- Focus on monitoring and understanding continued increases in SOBRA costs, including examination of what types of medical issues are occurring within this population.
- Monitor surrounding state and federal immigration law changes to anticipate their impact on the Kansas Medicaid SOBRA program.

Overview and Background

Program Description

The Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA), addressed the general question of how to help hospitals and other providers with the costs of treating undocumented persons in an emergency setting. Earlier federal legislation, the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 required Medicare-participating hospitals to treat and stabilize all emergency medical conditions. SOBRA was enacted by Congress to address the portion of these costs incurred by undocumented persons who are ineligible for Medicaid due to their citizenship status.

SOBRA requires all states to reimburse certain health care services through Medicaid. This act provided a funding stream for services already provided in hospital and physician offices by legal or professional obligation. As a result of this law, effective January 1, 1987, limited reimbursement became available for services provided to eligible non-U.S. citizens. Those services included hospital and physician care for life threatening emergencies and labor and delivery for pregnant women. Medical events covered under SOBRA are reimbursed through the Medicaid fee-for-service program at standard rates of reimbursement. The administration of SOBRA coverage has two components; an eligibility component and a medical necessity component.

The SOBRA process in Kansas begins with the determination of eligibility in the local SRS area office. The non-US citizen (or designee) contacts his or her local SRS area office after an event that she believes may qualify for SOBRA funding. The area office case worker will determine if the non US citizen meets eligibility requirements (for citizenship).

The case worker will then initiate the Kansas Medicaid reimbursement form (MS-2156) to determine medical necessity. If the medical event was a simple labor and delivery, and the non-US citizen meets all other requirements, the case worker may approve SOBRA eligibility for that particular medical event. If the event was something other than a simple labor and delivery, the case worker will send the MS-2156 form to the provider of the service. The provider then will attach appropriate medical records to the MS-2156 form and send all documents to the Medicaid fiscal agent (EDS).

The Medicaid fiscal agent will check the completeness of pertinent documents and contact the provider if more information is needed. EDS will then review the request and all medical records together with the SOBRA program manager. The program manager may approve, deny, or take the case to the Medical Workgroup committee. Once a decision is made based on the federal regulations, EDS sends the MS-2156 back to the area office with all pertinent information and final decision. The area office will notify the applicant of the decision. The applicant has the right to appeal the decision.

Definitions

In order to qualify for full Medicaid, the individual must be a U.S. citizen or meet specific immigration rules. During the application process all applicants are asked to declare if they are a citizen or non-citizen. Those reporting to be a citizen must provide proof of citizenship and identity. Those indicating they are not a citizen must provide information regarding their immigration status. This information is then verified with the Department of Homeland Security. Full Medicaid coverage for non-citizens is limited to: refugees; veterans; persons who attained Legal Permanent Resident Status more than 5 years ago; and a small number of other individuals with specific immigration statuses. Other non-citizens, including the undocumented, cannot receive Medicaid coverage, but may qualify for SOBRA coverage. Persons who may be covered under SOBRA include undocumented individuals, but also immigrants who fail to meet Medicaid criteria.

Federal regulations outline who is eligible for SOBRA services. These services and general provisions are defined under Federal Regulations in 42 CFR Part 440 Subpart B and Services Sec. 440.255. Citizenship and alienage requirements are defined in Sec. 435.406:

Definitions under SOBRA

42CFR440.255 Limited services available to certain aliens

(c) Effective January 1, 1987, aliens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if—

(1) The alien has, after sudden onset, a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

(i) placing the patient's health in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part, and

(2) the alien otherwise meets the requirements in secs. 435.406(c) and 436.406(c).

Alien is defined as an individual who is not a U.S. citizen or U.S. national.

U.S. National is defined as an individual who owes his sole allegiance to the United States, including all U.S. citizens, and including some individuals who are not U.S. citizens. These individuals would include citizens of certain U.S. possessions.

U.S. Citizen is defined as:

1. An individual born in the United States

2. An individual whose parent is a U.S. citizen
3. A former alien who has been naturalized as a U.S. citizen
4. An individual born in Puerto Rico
5. An individual born in Guam
6. An individual born in the U.S. Virgin Islands

Immigrant is defined as an alien who has been granted the right by the U.S. Citizenship and Immigration Services (USCIS) to reside permanently in the United States to work without restrictions in the United States.

Nonimmigrant is defined as an alien who has been granted the right by the USCIS to reside temporarily in the United States.

Illegal Alien (undocumented alien) is defined as an alien who has entered the United States illegally and is deportable if apprehended, or an alien who entered the United States legally but who has fallen "out of status" and is deportable.

Kansas' SOBRA program operates under strict federal guidelines with very limited flexibility. A key challenge in administering the SOBRA program is consistent application of the federal definition of covered medical claims (other than labor and delivery). Because eligibility, population, and service requirements are strictly defined by the Code of Federal Regulations, SOBRA coverage is also very limited. Using medical records as evidence, caseworkers review SOBRA requests to determine whether treatment provided to an undocumented person qualifies as a life threatening emergency under SOBRA.

National Data

Non-U.S. citizens are often uninsured or underinsured. In 2007, 44% of non-citizens under 65 had no health insurance. There are 9.7 million uninsured non-citizens, a majority of whom are undocumented, representing over 20% of the nation's uninsured population (U.S. Bureau of the Census, March 2008).

According to the National Health Foundation, non-U.S. citizens establish social connections in their place of origin (and places abroad) using border-crossing social networks. Through these connections or networks, they learn and inform each other about where to go, how to gain employment, and how to find a place to live in the United States. Through these ties they can also maintain families, utilize economic opportunities, keep informed on political interests and maintain cultural practices. Non-U.S. citizens can be found working in multiple areas of employment within the United States. About 3% work in agriculture; 33% have jobs in service industries; and substantial numbers can be found in construction or related occupations (16%), and in production, installation and repair industries (17%) (Vertovec, 2007). Young, unmarried men have been found to have repeat illegal border-crossing episodes; this likelihood falls with marriage, and increases again with children (National Health Foundation, 1993).

There remains controversy regarding undocumented immigrants and their use of social services, including health care. The Western Journal of Medicine completed a survey of undocumented persons residing within the United States which reported that 8.6% of emergency department visits are by undocumented immigrants. Among the undocumented immigrants surveyed, 86% stated they planned to remain within the United States, 80% cited a lack of funding as a reason for seeking emergency department care, and 44% stated that even if care was available elsewhere only

the emergency department was acceptable (Chan, Krishel, Bramwell and Clark, 1996).

The National Health Foundation states undocumented persons commonly use hospital and emergency services rather than seeking preventive medical care. For example, the utilization rate of hospitals and clinics by undocumented aliens (29%) is more than twice the rate of the overall United States population (11%) (U. S. Bureau of the Census, May 2008). In Kansas, there are three sources of care and funding that help address this gap in prevention for undocumented persons, which are described below.

Other Resources for Undocumented Persons

The Kansas Department of Health and Environment (KDHE) administers the Migrant Seasonal Farmworker program. This program coordinates a statewide voucher case management system for migratory and seasonal farmworkers. Vouchers for covered services are obtained from Access Point Agencies made up of state-funded primary care clinics and local health departments. This program allows health care organizations approved as Access Point Agencies or participating as Referral Providers to request payment for the following services: immunizations, screening tests, child and adult physical examinations, office visits, laboratory and X-ray services, vision care, pharmaceuticals, dental, and prenatal care.

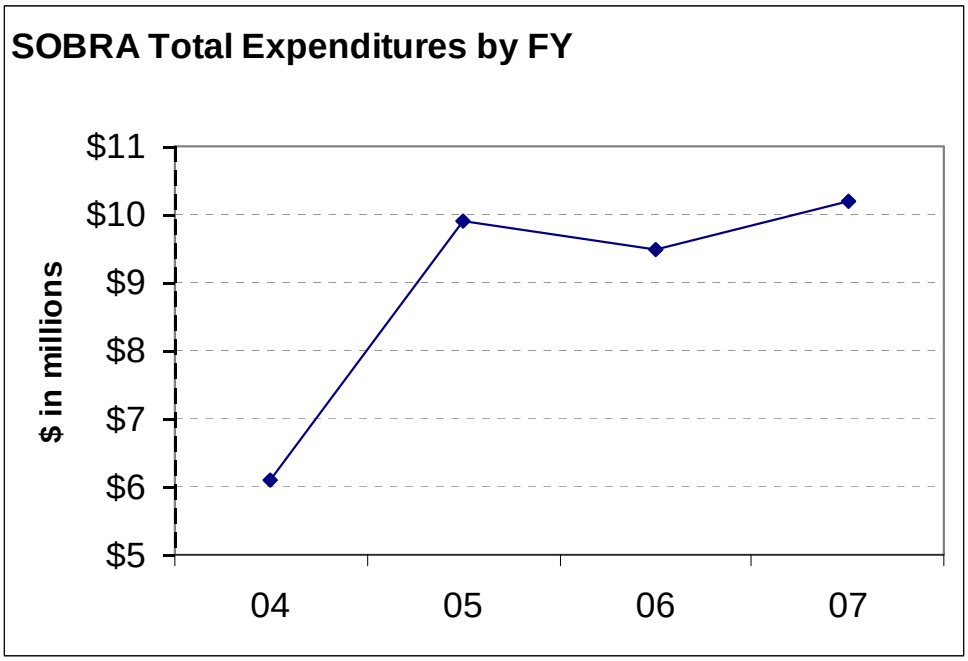
The Kansas Department of Health and Environment and the Kansas Department of Social and Rehabilitation Services (SRS) jointly provide the refugee program. When refugees arrive in the United States, they pass through the U.S. Public Health Services Quarantine State at their port of entry. Documents that outline the refugees' settlement information and medical records are sent to the State Refugee Health program and/or local health department. Local sponsors notify the county health department and arrange for health screenings. These services are funded by the U.S. Department of Health and Human Services Refugee Medical Assistance (RMA), Medicaid, and if appropriate, state grant funds.

Most primary care clinics and Community Health Centers operating in the state are members of the Kansas Association for the Medically Underserved (KAMU), the state's primary care clinic organization. Members are safety net providers whose primary mission is to assure access to comprehensive health care for underserved populations, including non-citizens. These are State funded primary care clinics, Federally Qualified Health Centers (FQHCs), local health departments and other non-profit clinics established and supported in part by public funds, faith-based organizations, individual volunteers, private foundations, or local donations. One such clinic serving a large number of non-citizens is the United Methodist Mexican-American Ministries clinics located in Garden City, Dodge City, Liberal, and Ulysses. These clinics offer family practice medical clinics, special health programs, AIDS case management and oral health education. They also offer food and clothing banks, Bibles and Christian materials, parenting classes, documentation assistance, and volunteer income tax assistance.

Service **U**tilization and **P**rogram **E**xpenditures

Figure 1 shows the total expenditures for SOBRA claims from FY 2004 through FY 2007. Total SOBRA reimbursements increased substantially in 2005, and dipped in 2006 before rising again in 2007. Expenditure increases in 2005 were likely due to both a substantial increase in claims as well as a significant increase in hospital reimbursement rates by Kansas Medicaid.

Figure 1



Labor and delivery is routinely the largest SOBRA expenditure. Non-U.S. citizens may migrate to the United States before their child is born. If born in the United States, the child is automatically a United States citizen.

Medical services (other than labor and delivery) are limited to those services related to the sudden onset of life-threatening emergencies. Approximately 50% of medical SOBRA requests (non labor and delivery) are denied because they do not meet federal guidelines for coverage. In 2007, there were 576 requests for non-labor and delivery medical services. Of those 576 requests 281 were approved and 295 were denied. It is important to note that in Kansas, SOBRA requests are always made after the event has occurred. Due to the time it may take for a case to completely process, the claims may not be submitted until several months after the event.

Figure 2 depicts the total number of SOBRA claims processed within the MMIS system by fiscal year. An increase in claims was seen in FY 2005, followed by declines in both 2006 and 2007.

Figure 2

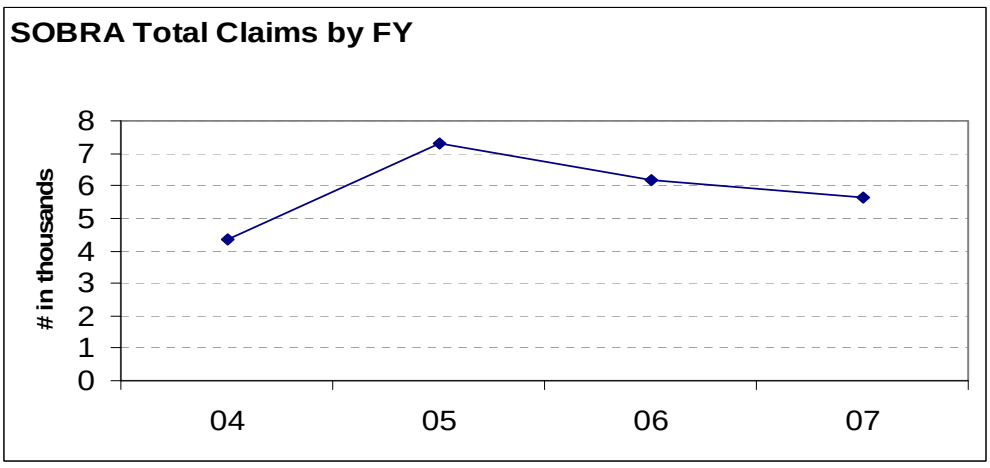


Figure 3 depicts the FY dollar per claim for the SOBRA population. This data portrays an 18% increase in expenditures per claim in FY 2007.

Figure 3

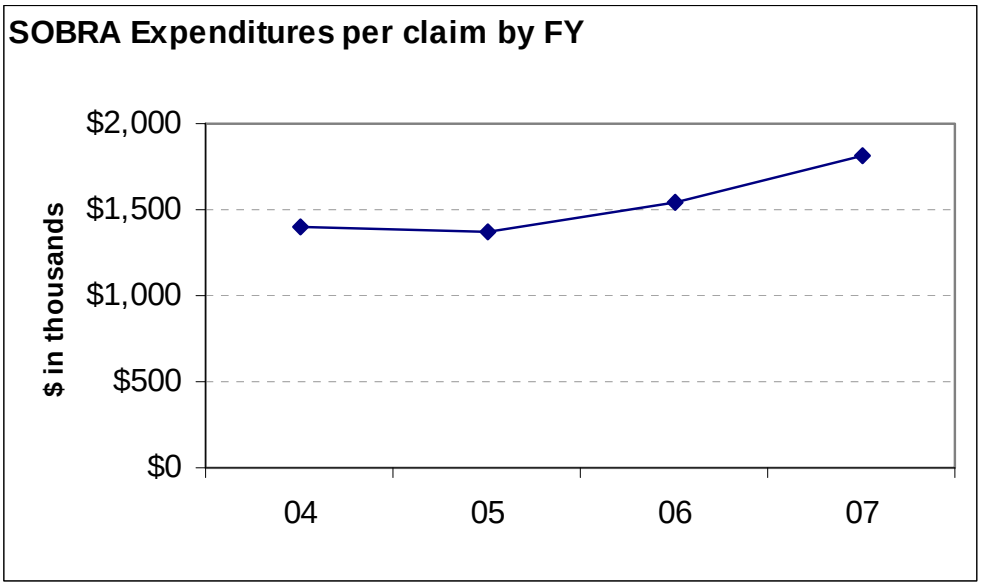


Figure 4 provides information about the SOBRA claims volume trends during different times within the fiscal year. This graph shows two drops in January and April of 2005. This decrease coincides with Congressional attention on potential changes to immigration laws.

Figure 4

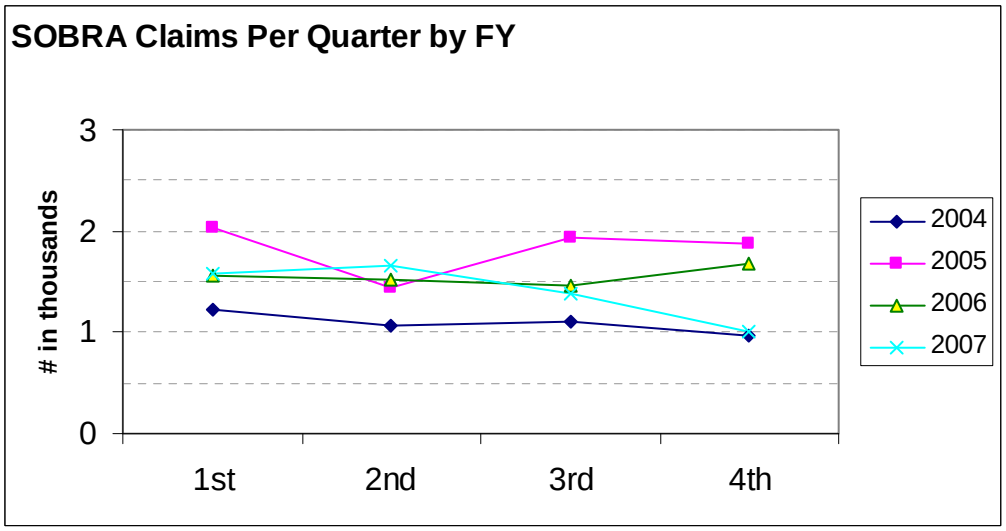
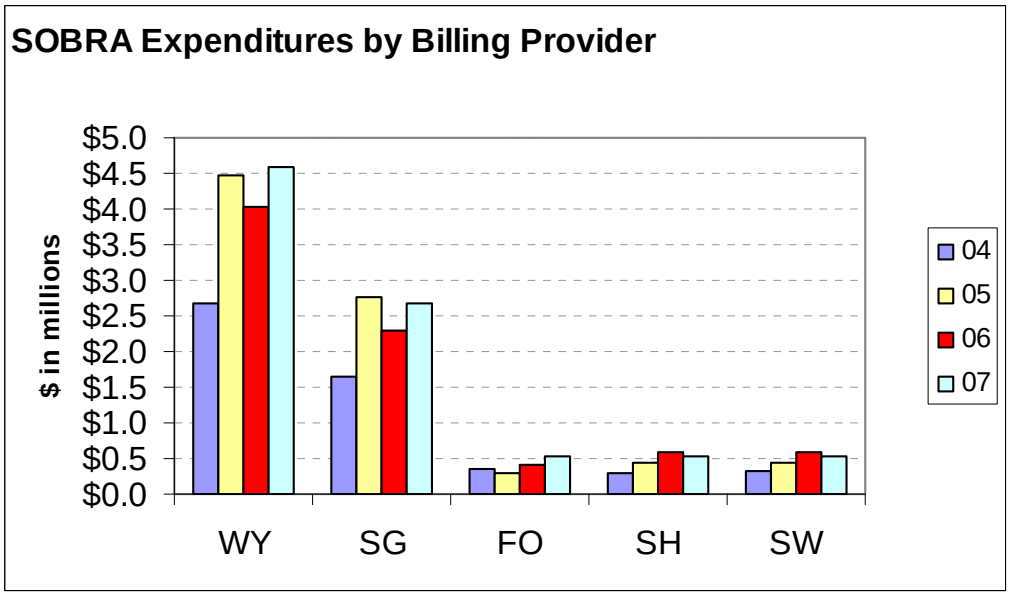


Figure 5 depicts the counties with the greatest amount of SOBRA reimbursements: Wyandotte, Sedgwick, Ford, Shawnee, and Finney. Between 2000 and 2006 the Kansas population increased by 2.6% with approximately 5.4% of this increase directly attributable to immigration. Usual sources of employment for immigrants consist of agriculture, service industries, construction, production, and installation and repair. Ford County (Dodge City) has experienced a substantial increase in immigration. Nevertheless, growth in SOBRA reimbursements in FY 2007 is greatest in Wyandotte and Sedgwick counties.

Figure 5



The SOBRA expenditures for Labor and Delivery are greater than other medical services. This is due to the limitations placed on medical services by the Code of Federal Regulations. This information is illustrated in Figure 6.

Figure 6

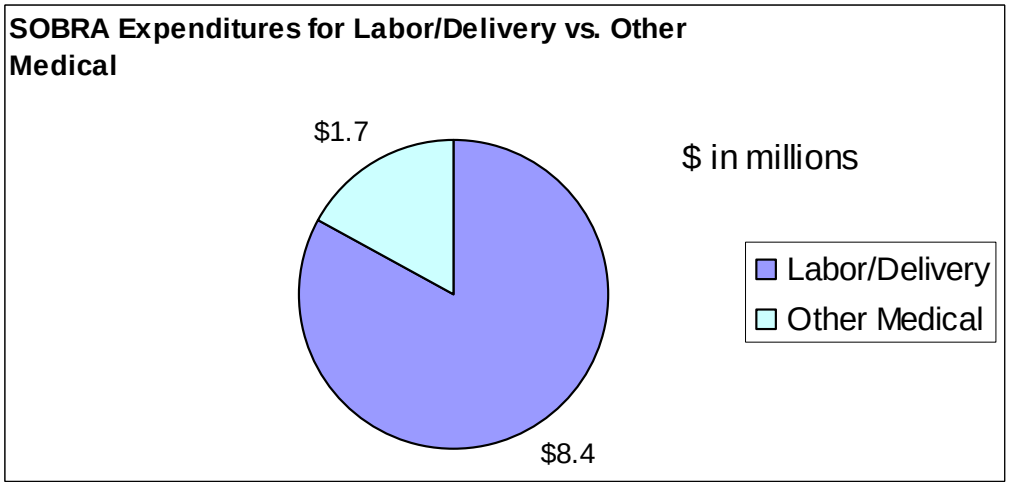


Figure 7 portrays the top six procedures codes billed by physicians for SOBRA services, which are all associated with labor and delivery services.

Figure 7

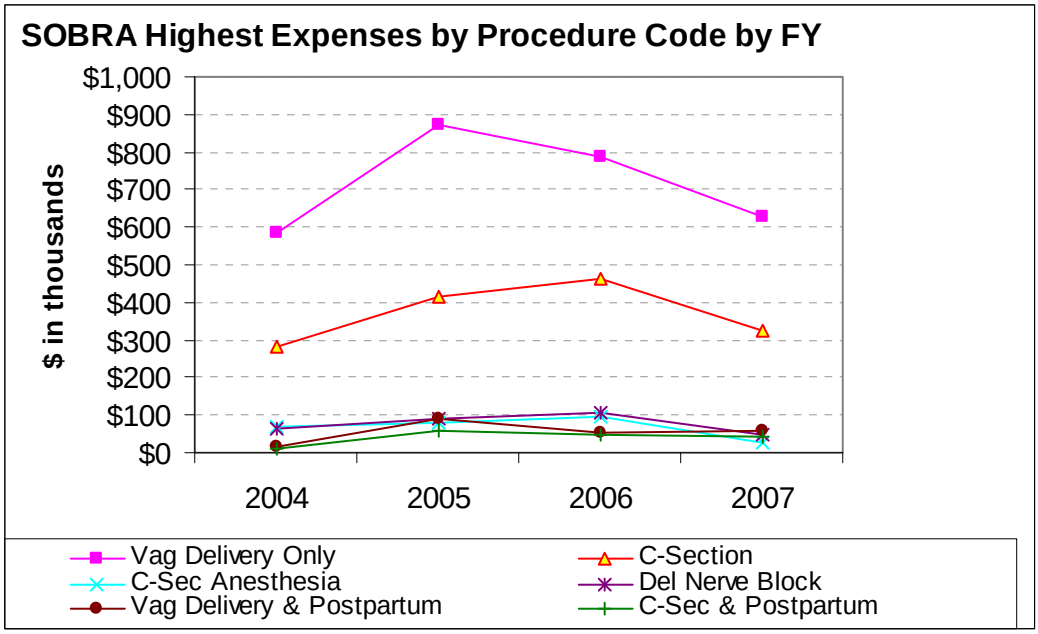


Table 1 identifies the six Diagnosis Related Group (DRG) codes (or bundled services provided in an inpatient hospital setting) most frequently billed for SOBRA services. The most frequently billed pregnancy related DRG's have been grouped together (370 thru 374, 376, 378, 383). The other types of medical services provided frequently within the hospital setting are trauma related. The categories with a zero indicate that the DRG's included in that category did not exist at that time.

Table 1
Highest-Cost Hospital Services in SOBRA by FY

FY	Pregnancy	Tracheotomy	Trauma OR	Trauma Brain	Coronary	Appendectomy
04	$4,602,137	$0.0	$0.0	$14,771	$0.0	$15,247
05	$6,663,452	$37,769	$20,272	$18,509	$0.0	$118,493
06	$7,085,672	$213,420	$10,063	$118,941	$104,109	$75,772
07	$7,411,272	$401,166	$145,775	$31,809	$59,460	$59,136

Program Evaluation

Nine years ago the SOBRA program was managed by non-medical staff; claims were paid based on diagnosis codes automatically through the MMIS system. This process created a large payment and eligibility error rate. In 2000, management of the program was assigned to medical staff. The MS -2156 reimbursement process was also changed to include a manual review of every request. This aligned SOBRA payments more closely with federal regulations. In 2004, a policy was written to allow simple labor and delivery cases to be approved by the area office case worker, and claims to be automated within the MMIS system. This reduced the fiscal agent's workload for SOBRA requests by 50% and allowed them to focus on more difficult and potentially costly cases. Currently, the simple labor and delivery reimbursements are still received and approved in the local SRS area offices. KHPA's fiscal agent (EDS) continues to process all non labor and delivery cases. All SOBRA claims are reviewed before payment by the appropriate staff at EDS. Each quar-

ter EDS staff review SOBRA claims for payment errors. The current error rate is less than one percent.

> **Payment Error Rate Measurement** was developed by the Center for Medicare and Medicaid Services (CMS) to comply with the Improper Payments Information Act of 2002 (Public Law 107-300). This law requires the heads of Federal agencies to review programs on an annual basis that are susceptible to significant erroneous payments and to report estimates to Congress. They are also required to submit actions the agency is taking to reduce the amount of improper payments. The Office of Management and Budget (OMB) identified Medicaid as a program at risk for significant improper payments. CMS now requires state Medicaid programs to participate in a program of reviewing Medicaid and SCHIP eligibility decisions and claims payments to produce state and national error rates.

The SOBRA program is affected by changes made in Congress, the state legislature, political arenas, job availability, farming seasons, etc. For example, Oklahoma recently enacted new state legislation (HB 1804) restricting undocumented immigrants from obtaining government IDs or public assistance. It also gives police the authority to check the immigration status of anyone arrested, which can lead to deportations. The law also makes it a felony for U.S. citizens to knowingly provide shelter, transportation or employment to undocumented immigrants. These changes in Oklahoma could potentially cause migration northward to Kansas for undocumented populations.

Conclusions

SOBRA reimbursements for emergency health care for undocumented persons rose by 18% in FY 2007 after a slight decline in 2006, and a near-doubling of expenses in 2005. The number of health claims reimbursed peaked in 2005 and fell in both 2006 and 2007. These changes appear to be explained in large part by known fluctuations in immigration patterns and by reimbursement rate increases by the Kansas Medicaid Program in 2005 and 2006. However, spending in 2007 remains partially unexplained.

Recommendations

1. Add a category to the current SOBRA Database maintained by EDS to include the medical issue for each MS-2156 reimbursement form submitted.

2. Focus on monitoring and understanding continued increases in SOBRA costs, including closer views of what types of medical issues are occurring within this population.

3. Monitor surrounding state and federal immigration law changes to anticipate their impact on the Kansas Medicaid SOBRA program.

References

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