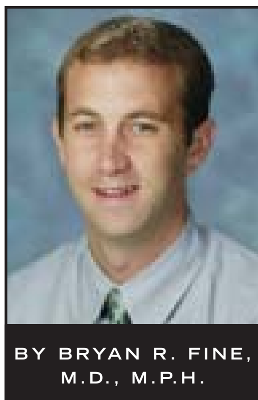
HEALTH POLICY: THE FINE LINE

Immigrants and Medicaid

An immigrant family came to our office recently. They have been in the country—legally—for 2 years now. They were asking if their children, now 6 and 3 years old, are eligible for Medicaid. What can I advise them?

Immigration reform has recently been a hot topic on the federal agenda. As economic prosperity in America continues to promise opportunity and security, the number of people striving for U.S. residency, either by legal or illegal means, will continue to be significant.


BY BRYAN R. FINE, M.D., M.P.H.

There are many ways that a foreign family can legally situate in the United States. They can be sponsored by family members who are U.S. citizens or by U.S.-based employers, or they can gain a path to citizenship via special lotteries reserved for certain countries or individuals.

There also are many ways that families can situate illegally in the United States, be it by overextending work visas, crossing unguarded land borders on foot, or arriving surreptitiously by boat. After using these illegal means, however, individuals live in the United States without Social Security numbers or other proof of identification.

In both situations—legal and illegal immigration—the question of health care for children involved represents a significant public health burden. At what point does the federal government assume some responsibility for the children of this population? What health care is available to children who don't qualify for government support but who need the services nonetheless?

Let's address the legal question first. By law, children cannot qualify for Medicaid services until they have been legally established in the United States for 5 years. This is a federal requirement that cannot be altered at the state level. States may offer their own programs of state-funded assistance for children who do not meet this requirement, but these children cannot receive federal Medicaid dollars.

Thus, neither the 6-year-old nor the 3-year-old members of the family in question, having been in the United States for only 2 years, are eligible for Medicaid, irrespective of family income. The family would be eligible for private insurance through an employer, could seek out care at federally funded community health centers on a sliding scale, and could receive care in emergency departments. Pro bono or reduced-cost care from willing independent practitioners also would be an option.

Concerning illegal immigrants, the situation becomes far more challenging. According to the Urban Institute, a nonpartisan economic and social policy research organization based in Washington, there are estimated to be more than 11 million undocumented immigrants in the United States—nearly 4% of the total population. Children who arrive in the United States illegally with their parents face many significant obstacles, including difficulties with school enrollment, language barriers, and lack of social services. The timely receipt of routine and emergent health care is an additional major problem. Many of these families are in low-wage, undocumented positions and have no access to private insurance. They are not, by absolute rule, eligible for Medicaid. They can seek out care at community health centers and emergency departments, but establishing a medical home—which is vital to ensuring child health—is extremely difficult to accomplish.

There is also the situation of children born in the United States to undocumented immigrants. These children are U.S. citizens by birth and are thus entitled to all of the federally protected rights of any other U.S. citizen, including Medicaid. However, fear of deportation frequently discourages undocumented parents from presenting to government offices with their U.S. citizen children, especially since the tightening of Medicaid rules in 2006.

Income and legal status notwithstanding, immigrant children often face cultural prejudices and social obstacles that make growing up difficult. Low-income immigrant children, facing these challenges as well as limited access to health care services and insurance coverage, can only take comfort in knowing that passing years may bring some improvement. Because undocumented, low-income immigrant children are so disadvantaged socioeconomically, they will likely remain a high priority of public policy intervention. ■

DR. FINE *is a pediatric hospitalist at Children's National Medical Center and an assistant professor of pediatrics at the George Washington University School of Medicine. To respond to this column, write to Dr. Fine at our editorial offices (pdnews@elsevier.com).*

Coalition Promises Physicians Free, Easy ePrescribing Access

BY JOEL B. FINKELSTEIN
Contributing Writer

WASHINGTON — Doctors who have yet to get on the health information technology bandwagon no longer have any excuses, according to members of the National ePrescribing Patient Safety Initiative, a coalition of health insurers and software companies.

The initiative—called NEPSI—is offering physicians' offices access to a secure, easy-to-use system that is compatible with the software in 99% of the nation's pharmacies, coalition members said at a press briefing. NEPSI also includes regional organizations, university hospitals, and medical centers, which will act as a support network for physicians using the online tool.

"According to [the Institute of Medicine], 1.5 million Americans are injured and more than 7,000 die from medication errors every year. As a practicing physician, I find that unacceptable," said Dr. Nancy Dickey, a family physician and president of the Health Science Center at the Texas A&M University in College Station.

In a report released last year, the IOM identified electronic prescribing as the single most significant step physicians can take to reduce drug-related medical errors. That report also found that many of the errors are caused by illegible handwriting, unclear abbreviations, and miscalculated doses.

"More than 3 billion prescriptions are written every year and even though we have the technology to make this problem virtually go away, less than one in five of my colleagues are using electronic prescribing," said Dr. Dickey, former president of the American Medical Association.

No More Excuses

Dr. Dickey said time and money have been major barriers for the adoption of electronic prescribing, despite the fact that widespread use of electronic prescribing could save the U.S. health care system as much as $27 billion, as estimated by the Center for Information Technology Leadership.

"Part of the problem is that the people who are being asked to take the time and to spend the money to put this in their offices—the physicians—aren't necessarily the ones who get the financial benefit," she said.

That's why the coalition has come together to offer physicians an option that is not only free, but takes 15-30 minutes to learn, said Dr. Dickey.

"It is a truly easy system," said Dr. Azar Korby, a family physician in Salem, N.H., who has been testing the software for the past year. Even someone who is not computer savvy should be able to learn the system in under 40 minutes, Dr. Korbey said.

NEPSI's efforts may be just the kickstart some physicians need, said Dr. Wilson Pace, director of the American Academy of Family Physicians' National Research Network and a member of the IOM committee that produced last year's report on medication errors.

"This appears to be a relatively safe way to try out something and get started for somebody who is not quite clear where they want to go," he said in an interview.

There also is a growing incentive to adopt electronic prescribing, Dr. Mark McClellan said at the NEPSI launch.

Part D plans already are required to support electronic prescribing and Medicare Advantage plans are moving toward adoption of similar standards. Even in traditional fee-for-service Medicare, the Centers for Medicare and Medicaid Services is expanding efforts to boost reimbursement to physicians who report quality data, said Dr. McClellan, former CMS administrator and now a senior fellow at the AEI-Brookings Joint Center, a Washington think tank.

"It all fits together in supporting the movement toward electronic prescribing to get to better quality care at a lower cost."

But this is not something that the government can achieve alone. Partners in the private sector are crucial, he said.

Patient Safety Is the Goal

To that end, the initiative is being wholly funded by the coalition of private stakeholders at an estimated cost of $100 million for the first 5 years. That is in contrast to other free electronic prescribing software that requires physicians to market personal health records or other products to patients.

The companies that are supporting and paying for NEPSI see this as an investment in the future, said Glen Tullman, chief executive officer of Allscripts Inc., which is leading the effort. "Down the road, we're very hopeful that this encourages adoption of full electronic health records and Allscripts is a leading provider of those health records," he said at the briefing.

"But I want to make it very clear that our first objective is to equip every physician in the United States with electronic prescribing software that is absolutely free of charge," Mr. Tullman added.

Such a large coalition of payers and vendors has the potential to put a real dent in the problem, said Dr. Pace.

"The primary care system in England is virtually all electronic. The driving force behind that initially ... was stand-alone prescription systems," he said.

It is not clear how physicians in this country will feel about adopting an electronic prescribing system that is not integrated with electronic medical records, but "there's no question it's a step up from paper," said Dr. Pace. ■

Who's on Board?

Members of the National ePrescribing Patient Safety Initiative include:

- **Aetna**
- **Allscripts Inc.**
- **Cisco Systems**
- **Dell Inc.**
- **Fujitsu Computers of America**
- **Google**
- **Microsoft Corp.**
- **Sprint Nextel**
- **SureScripts**
- **WellPoint**
- **Wolters Kluwer Health**
- **12 regional health care organizations**