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FACT SHEET
Obtaining Medicaid Coverage for Out-of-State Services

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People in the United States frequently travel from one state to another, for work, shopping, entertainment, vacations—and to obtain health care. Not surprisingly, disability rights advocates are increasingly being contacted by clients who need help obtaining health care from out-of-state health care providers. We will label these "interstate health care needs."

People go out-of-state to obtain health care for a variety of reasons. Many individuals live near the state border and have easier geographic and transportation access to health care services that are available in the state next door. The treating physician may refer his patient to an out-of-state specialty care provider who is recognized as being tops in the field of practice. Referral for specialty care or a residential placement may occur because there are no Medicaid-participating providers in-state who are willing to accept the client as a new Medicaid patient. An individual may need to obtain health care out-of-state due to an emergency.

The National Health Law Program will address interstate health care needs in two issue briefs. This fact sheet will address two aspects of interstate health care needs: (1) the situation where a resident of a state needs or wants to obtain services in another state and (2) the situation illustrated by *Duffy v. Meconi*, an ongoing Medicaid case where the plaintiff, who is institutionalized in one state, wants to migrate to another but cannot do so because she cannot establish eligibility for Medicaid in that state. The next fact sheet will focus on how to anticipate and address problems that may occur when people who have gone out-of-state to obtain health services are ready to return to their home state.

NOTE: These fact sheets briefs assume that the reader is familiar with the rules that govern who is a state resident. *See* 42 C.F.R. § 435.403 (rules for establishing state residency); 42 C.F.R. § 436.403 (same,

regarding Guam, Puerto Rico, and the Virgin Islands). For a detailed discussion of the residence regulations, *see* Sarah Somers, National Health Law Program, *Question & Answer: State Residence and Medicaid Eligibility* (Aug. 2004) (available from NDRN or NHeLP).

I. Obtaining care and services out-of-state

A. Federal Medicaid Law and Guidance

The Medicaid Act provides that a State plan for medical assistance must

> . . . provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;. . . .

42 U.S.C. § 1396a(a)(16).

Prior to 1978, federal regulations discussed coverage of out-of-state services, stating simply that the "state agency will facilitate the meeting of medical needs within the state for *residents from other states*." 45 C.F.R. § 448.40(a)(3) (promulgated at 25 *Fed. Reg.* 17719 (1970) (emphasis added)). In 1978, the federal Medicaid agency reorganized its regulations, moving § 448.40 to the current 42 C.F.R. § 431.52, and made "clarifying and editorial changes but no policy changes." 43 *Fed. Reg*. 45175 (1978). However, the emphasis of the regulation changed.

The regulation requires the State to

> pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State, and any of the following conditions is met:
>
> (1) Medical services are needed because of a medical emergency;
> (2) Medical services are needed and the recipient's health would be endangered if he were required to travel to his State of residence;[1]
> (3) The State determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more

[1] The now-superceded federal *Handbook of Public Assistance Administration*, Supplement D, Medical Assistance Programs, § D-5620.1.b (Oct. 7, 1966) included an additional factor that the health of the individual would be endangered if the care and services are postponed until he returns to the State of residence.

readily available in the other State; [2]

(4) It is general practice for recipients in a particular locality to use medical resources in another State.

42 C.F.R. § 431.52(b) (2007).

Under this regulation, a State Medicaid agency must pay for out-of-state services when the enumerated conditions are met, but only to the same extent that it would pay for services in-state. Keep in mind, however, that another Medicaid regulation requires participating providers to accept Medicaid payment as payment in full. According to that regulation, the State "must limit participation in the Medicaid program to providers who accept, as payment in full, the amount paid by the agency," plus any authorized cost sharing. *Id.* at § 447.15. This rule would apply to both in-state and out-of-state providers.

The federal regulations also require States to "establish procedures to facilitate the furnishing of medical services to individuals who are present in the State and are eligible for Medicaid under another State's plan." *Id.* at § 431.52(c). *See also* 42 C.F.R. § 435.403(a) ("The agency must provide Medicaid to eligible residents of the State, including residents who are absent from the State . . . [as] set forth in § 431.52."); *Id.* at § 436.403(a) (same, regarding Guam, Puerto Rico, and the Virgin Islands). The United States Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) has published the *State Medicaid Manual* to provide additional guidance to the States. [3] The *State Medicaid Manual* says that states can establish "interstate agreements" with other states to facilitate out-of-state coverage and/or resolve cases of disputed residence. *See* CMS, *State Medicaid Manual,* § 3230.4. The agreement may be very limited or very broad, for example, pertaining to one individual, all institutionalized individuals, or all individuals. *See Id.* Where the agreement is dealing with cases of disputed residency, it must contain a procedure for providing Medicaid to individuals pending resolution of the case. *See Id.* The *State Medicaid Manual* also suggests that states can have an "open agreement" that allows all or certain individuals who are physically present in the State to be residents of the State although they may not meet the definition of

[2] The *Handbook of Public Assistance Administration* included an additional factor that the availability of the out-of-state care or resources makes it "desirable for the individual to use medical facilities outside the State for short or long periods, in accordance with plans developed jointly by the agency and the individual, consistent with medical advice." *Id.* at § D-5620.2.b. In considering this factor, the *Handbook* also noted that "the nature of the medical need or the availability of relatives or friends who can provide essential supportive or supplemental help or care, constitute factors that may be considered in determining whether the use of medical resources outside the State would be in the best interests of applicants or recipients." *Id.* at § D-5630.1.

[3] While not a regulation, state Medicaid plans (state plans) typically expressly agree to adhere to the requirements contained in the *State Medicaid Manual*. In addition, courts often defer to the *State Medicaid Manual.* See Sarah Somers, National Health Law Program, *A Medicaid Advocate's Guide to Deference* (Jan. 2008) (available upon request).

being a resident of that State under 42 C.F.R. §§ 435.403 or 436.403. *See* CMS, *State Medicaid Manual,* § 3230.5. An "open agreement" does not have the same effect as an "interstate agreement" since it only waives residency criteria in one State. Therefore, an individual who is physically residing in a State with an "open agreement," but is a resident of another State may choose one of the two States as his/her State of residence for Medicaid purposes. *See Id.*

Finally, according to yet another *State Medicaid Manual* provision, when two or more states cannot resolve which State is the State of residence, the State where the individual is physically located is the State of residence for Medicaid purposes. *See Id.* at § 3230.6.

B. Applications in federal guidance documents

CMS, *State Medicaid Manual*

The CMS *State Medicaid Manual* gives a few examples of how the out-of-state coverage rules work in practice:

- *Placement of an individual by State A in an institution in State B.* When an agency of State A arranges for an individual to be placed in an institution located in State B, the agency is recognized as acting on behalf of State A. The State or the agency making the placement on behalf of State A retains responsibility for that individual and remains the state of residence for Medicaid purposes, irrespective of the individual's intent or ability to indicate intent. *See* CMS, *State Medicaid Manual,* § 3230.D.

  State A also retains responsibility for an individual when it initiates placement, because the State lacks a sufficient number of appropriate facilities to provide services to its residents. *See Id.* at § 3230.D. However, if a competent individual leaves the facility in which he/she is placed by a State, the individual's State of residence for Medicaid purposes is the State where the individual is physically located. *See Id.*

  The provision of basic information to individuals about another State's Medicaid program or the availability of services and facilities in another state does not constitute placement by the State, nor does assisting an individual in locating an institution in another State, provided the person is competent and independently decides to move. *See Id.* at § 3230.E.

- For Individuals of any age who are receiving *federal payments for foster care* under title IV-E of the Social Security Act and for individuals with respect to whom there is an *adoption assistance*

agreement in effect under title IV-E, the State of residence is the State where the individual is living. *See* CMS, *State Medicaid Manual,* § 3230.G. As a result, if the individual is living in State A, State A will be responsible for their Medicaid payments even though State B is making the title IV-E payment or was the State where the adoption assistance agreement was entered. *See Id.* at § 3230.3.D.

- *Individuals involved in transient work* who go to another State seeking employment have two choices—the individual can establish residence in the State in which he/she is employed or seeking employment, or the individual may wish to claim one particular State as his/her State of residence. Thus, for example, a migrant worker who resides in State A and returns to State A every year may choose to retain State A as his residence or may change his State of residence as he goes from State to State. *See* CMS, *State Medicaid Manual,* § 3230.3.B. Also, when an individual has a spouse in the military service and is residing in State B because of the spouse's military assignment, the individual may choose State B as his/her State of residence due to the spouse's job commitment or the individual may choose State A as the State of residence because he/she considers it their permanent residence. *See Id.*

CMS, Olmstead No. 3

One of the federal "Olmstead Letters" also discusses out-of-state services in the context of home and community-based waivers. *See* CMS, *Dear State Medicaid Director: Olmstead Update No. 3* (July 25, 2000) (Olmstead No. 3). While the letter notes that out-of-state services have been provided by many states "with excellent results," it also cautions that distant residential placements for people with disabilities may not be an appropriate option. "Services provided in a location remote from the individual's family and friends may not provide appropriate support for the person to live [out of state] in the most integrated setting appropriate to his needs." *Id.,* Attachment 3-e.

Olmstead No. 3 also reminds states that standard requirements applicable to all waivers must be met, including:

- Identifying the specific out-of-state services in the individual's plan of care, including the amount and type of each service and type of provider;
- Ensuring that providers meet the standards for providing services that are set forth in the waiver as well as any other state standards of licensure or certification;
- Assuring that the health and welfare of the beneficiary are

protected. Oversight may be provided by either the host state or the resident state;

- Ensuring that individuals have free choice of provider to the same extent that they are allowed to choose among providers of in-state services, citing 42 U.S.C. § 1396a(a)(23); and
- Requiring provider agreements with the Medicaid agency and that payments be made directly to the provider.

These requirements may be met directly by the State or indirectly through an interstate compact in which the second State attends to provider agreement and payment activities. *See also* 42 C.F.R. § 431.52(b) (requiring State to "pay for services furnished in another State to the same extent that it would pay for services furnished within its boundaries if the services are furnished to a recipient who is a resident of the State"). Olmstead No. 3 also encourages states to be "quite creative in their utilization of [interstate] compacts to foster efficient and responsive [home and community-based waiver] programs" and "recognizes it as an opportunity to expand Medicaid services to meet the needs of individuals in the most integrated settings appropriate". *Id.*

C. Applications in the case law

There is very little case law dealing with disputes over interstate health care needs. The most noteworthy cases address the issue of whether states can pay lower rates to out-of-state hospitals. In *West Virginia Univ. Hosps. Inc. v. Casey*¸ 885 F.2d 11 (3d Cir. 1989), *aff'd on other grounds*, 499 U.S. 83 (1991), the Third Circuit decided that the Pennsylvania Medicaid agency could not set disproportionately lower rates for out-of-state hospital services (including disproportionate share hospital adjustments), rendered to its Medicaid enrollees merely because the hospital was an out-of-state provider. *See Id.* at 17-22, 28-29. The out-of-state provider, West Virginia University Hospital (WVUH) was located about six miles from the border between West Virginia and Pennsylvania and, due to its proximity to the border, provided inpatient care to hundreds of Pennsylvania residents. The Circuit Court found that the rate differential for out-of-state hospitals violated the "reasonable and adequate" payment requirement of the Boren Amendment, 42 U.S.C. § 1396a(a)(13), as it existed in 1989. However, the Boren Amendment was subsequently repealed by Congress.

In *Children's Seashore House v. Waldman*, 197 F.3d 654 (3d Cir. 1999), the Court found that the payment differential did not violate section 1396a(a)(13), as amended, but reversed and remanded the district court's order dismissing the hospital's equal protection claim. *Id.* at 662. Meanwhile, WVUH and Pennsylvania became embroiled in another dispute when Pennsylvania passed a law that made enhanced Medicaid payments for trauma care available to only in-state hospitals. WVUH complained that the policy violated the Medicaid Act, 42 U.S.C. § 1396a(a)(16), the Equal Protection Clause, and the Commerce Clause.

The district court ruled on all the claims. *See West Virginia Univ. Hosps., Inc. v. Rendell*, Civ. No. 1:CV-06-0082, 2007 WL 3274409 (M.D. Pa. Nov. 5, 2007). Citing *Gonzaga Univ. v. Doe,* 536 U.S. 273 (2002), the Court held that health care providers cannot enforce section 1396a(a)(16). 2007 WL 3274409 at **5-6. However, the Court granted WVUH's motion for summary judgment on the equal protection claim, finding no rational basis for the disparate trauma payments based on out-of-state hospital status. *Id.* at **7-8. The Court also decided that the policy violated the Commerce Clause. *Id.* at *10. *See also Children's Hosp. & Med. Ctr. v. Bonta,* 97 Cal. App. 4th 740, 118 Cal Rptr. 2d 629 (Cal. App. 1 Dist. 2002) (holding that California violated the Equal Protection Clause by reimbursing out-of-state hospitals at a lower rate than in-state hospitals for Medicaid care for California residents).

In another case, *Planned Parenthood of New York City v. N.J. Dep't of Instns. & Agencies*, 75 N.J. 49, 379 A.2d 841 (1977), the New Jersey Supreme Court refused to require New Jersey Medicaid to reimburse abortion procedures provided by New York providers that would not be covered under New Jersey law: "Were we to adopt plaintiff's position, we would, in essence, have reached the odd conclusion that although Congress did not intend to compel states to subsidize the costs of non-therapeutic abortions within the state, it did intend to mandate reimbursement for identical procedures performed outside the state." *Planned Parenthood of New York City ,* 75 N.J. at 54 n.1. The plaintiff cited to the court the regulation that requires coverage when it is the general practice for residents to use medical resources outside the state. However, the Court found this provision becomes effective only if the plan provides for such care and services within the State. *See Id.* at 53. The Court also pointed out that 42 U.S.C. § 1396a(a)(1) requires the Medicaid plan to be in effect statewide and reasoned, "If a state provided certain medical assistance to eligible residents who happened to have access to medical facilities and services outside the state, and not to those who did not have such access, the substance of the plan would be governed by the geographical convenience of the medicaid recipient contrary to the spirit of the statewide criteria. . . ." *Id.* at 54. *Compare Elliott v. State Dep't of Soc. & Rehab. Servs.*, 597 P.2d 679 (Kan. App. 1979) (Kansas resident who obtained specialized care for the mentally retarded in another state could establish Kansas Medicaid eligibility if comparable care could not be obtained in Kansas); *White v. Lavine*, 410 N.Y.S.2d 729 (N.Y. App. Div. 4 Dept. 1978) (New York resident who obtained medical care in Ohio without proving the limitations of that care in New York was not entitled to New York Medicaid coverage of the care).

II. Addressing barriers to changing State of residence: *Duffy v. Meconi*

States are required to provide Medicaid benefits to eligible residents of the state.[4] The basic rule (for individuals over 21 who do not live in an institution and

[4] *See* 42 C.F.R. § 435.403(a).

have the capacity to form intent) is that the state of residence is the state in which the individual is living with the intent to remain there permanently or for an indefinite period.[5] For individuals under 21 who don't live in an institution, their state of residence is generally the same as their parents.[6]

The residence rules become more complicated for individuals who are institutionalized but lack the capacity to form intent. Generally, for individuals who lost the ability to form intent after the age of 21 (for example, because of senile dementia or a brain injury), their state of residence is the state in which they are living, unless another state has placed them in the institution.[7] For individuals who never had the capability of forming intent or lost it before age 21 (for example, people born with severe mental retardation), the state of residence is generally the state of residence of the parents at the time of placement.[8]

Despite these rules, individuals who live in institutions may encounter difficulties when trying to move. These difficulties may implicate an individual's constitutional rights. Courts have grappled with these problems with different results.

A. The Constitutional Right to Travel or Migrate

The U.S. Supreme Court has repeatedly recognized that citizens have a fundamental right to travel. One aspect of the right to travel is the right of newly-arrived citizens to enjoy the same privileges and immunities as other state residents. In the landmark case discussing public benefits, *Shapiro v. Thompson,* the U.S. Supreme Court struck down state requirements denying cash assistance benefits to individuals who had not lived in a state or District of Columbia for a certain duration immediately preceding their applications for assistance. 394 U.S. 618 (1969). The Court held that the requirement violated both the Equal Protection Clause and the constitutional right to travel. citation The Court held that the right to travel was a fundamental right and that "any classification [such as distinguishing between old and new residents] which serves to penalize the exercise of that right, unless shown to be necessary to promote a compelling governmental interest, is unconstitutional." *Id.* at 634. A state's desire to preserve the fiscal integrity of its programs did not meet this heightened level of scrutiny and thus did not justify the infringement of constitutional rights. *See Id.* at 633.

In 1999, the Court invalidated a California statute that restricted eligibility

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[5] *See Id.* § 435.403(i)(1).

[6] *See Id.* § 435.403(h)(4)(i).

[7] *See Id.* § 435.403(i)(3).

[8] *See Id.* § 435.403(i)(2).

for welfare benefits to the amount that they family would have received in their former state of residence when the family had resided in California for less than twelve months. *Saenz v. Roe,* 526 U.S. 489 (1999). The Court held that this scheme constituted a "discriminatory classification" that impeded the right to travel, which includes a citizen's right to be treated equally in her new state of residence. *See Id.* at 505. As in *Shapiro*, the court found that the state's interest in saving money, while legitimate, did not justify the requirement.[9] *See Id.* at 507. Currently, it is not perfectly clear what level of scrutiny is required when evaluating infringements on the right to travel in general. However, when considering residence requirements for public benefits, courts have followed *Shapiro* and applied heightened scrutiny. *See, e.g., Warrick v. Snider*, 2 F. Supp. 2d 720, 723 (W.D. Pa. 1997).

While Medicaid's residency requirements are designed to avoid some violations of the right to travel, they still present problems. The requirements can effectively trap institutionalized individuals in the state in which they currently live. CMS recognized that the residence of institutionalized individuals can present problems, enacting a regulation that provides that a state "agency may not deny Medicaid eligibility to an individual in an institution, who satisfied the residency rules set forth in this section, on the grounds that the individual did not establish residence in the state before entering the institution."[10] However, this regulation does not help many people as the only institutionalized individuals who could travel would be those very few who could obtain a privately paid placement in another state's institution before applying for Medicaid in a new state.[11]

B. Active Case Example: *Duffy v. Meconi*[12]

Marianne Duffy is a 35 year-old woman with severe mental retardation, autism, and blindness. Since she was very young, she has been living in institutional settings. She needs a highly structured and supervised environment

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[9] Waiting periods of shorter duration may also be unconstitutional. At least one state attorney general has opined that a 90 day residency requirement for Medicaid eligibility would violate the right to travel. *See* Letter from Thomas W. Corbett, Jr., Attorney General of Pennsylvania to Feather O. Houstoun, Secretary of Public Welfare, Dec. 9, 1996 (available from National Health Law Program). *Cf. Warrick v. Snider*, 2 Fed. Supp. 2d 720 (W.D. Pa. 1997) (striking down 60 day residency requirement for general cash assistance).

[10] 42 C.F.R. § 435.403(j)(2).

[11] Moreover, this effect is contrary to the intent expressed by CMS, which stated that the regulation would not prohibit a Medicaid beneficiary from establishing residency in a new state, in particular in the case of an adult who became incapable of indicating intent before age 21 and whose parents/guardians wished to move him to an institution in a new state of residence. *See* 44 Fed. Reg. 41434, at 41436-37 (July 17, 1979).

[12] Counsel in this case are MaryBeth Musumeci and Daniel Atkins of the Disabilities Law Program of the Community Legal Aid Society, in Wilmington, DE, and Sarah Somers and Jane Perkins of NHeLP.

because she has seizures, falls and engages in self-abusive behavior. For 14 years, she has lived in an intermediate care facility for people with mental retardation (ICF-MR) in North Carolina. She was covered by Medicaid, which paid for her ICF-MR services.

In 2001, her parents moved to Delaware. Their plan was to apply for Delaware Medicaid for Ms. Duffy and find a Medicaid-covered residential placement for her. It is necessary to have residential and supportive services in place because Marianne's disabilities make it impossible for her parents to safely care for her in their home for even a few days.

When her parents applied for Medicaid, however, they were told that Ms. Duffy was not eligible because she was not a Delaware resident. She was a North Carolina resident and in order to become a resident, she would have to be physically present in the state. Her parents argued that they needed a safe residential placement for her before she could come to Delaware. The state health officials refused to determine her eligibility until she actually physically relocated to Delaware.

Ms. Duffy is essentially stuck in North Carolina. She cannotphysically relocate to Delaware without an appropriate placement into which she can move. However, she cannot afford such a placement without Medicaid coverage. Because Delaware would not change its position, she sued, arguing that the state's application of the residence regulations violates her right to travel under the U.S. Constitution.

The Delaware District Court granted Ms. Duffy's motion for summary judgment, holding that the state's application of the residency criteria violated her right to travel.[13] *Duffy v. Meconi,* 508 F. Supp. 2d 399 (D. Del. 2007). The court held that the right to travel was fundamental, therefore any burden on that right must be subject to strict scrutiny. Thus, Delaware's policy must be narrowly tailored to justify a compelling state interest. *See Id.* at 406. The court recognized the burden placed on Ms. Duffy, stating that "while [she] may not be literally 'trapped in North Carolina,' it is certainly true that the State of Delaware has impeded her ability to relocate to Delaware by refusing to process and approve her application for Medicaid until she physically resides in the State." *Id.* at 406. The state attempted to justify its policy with "a desire to 'fairly apportion the State's limited funds to those residents who need it most.'" *Id.* The court rejected that argument as insufficiently compelling. *Id.* at 406-07.

Delaware has appealed this decision to the U.S. Court of Appeals for the Third Circuit. The case has been briefed and, at the time of writing, no oral argument has been set.

[13] In the same opinion, the court denied the Defendants' motion for summary judgment. The court had previously denied Defendants' motion to dismiss. *See Duffy v. Meconi,* 395 F. Supp. 2d 132 (D. Del. 2005).