Developing the Minnesota Cancer Plan
Step 2: Recommend Objectives and Strategies

Workgroup: Treatment **Date:** June 24, 2016

Objective: Revise Minnesota's Emergency Medical Assistance (EMA) policy to cover medical care related to the patient's cancer diagnosis and treatment, to the same extent as Medical Assistance (MA).

Desired Outcome:

At the end of five years, what would you like to accomplish? If you do not expect to achieve the objective by the end of five years, what would success look like?

Alignment:

Partners currently working on this objective and type of activity:

Organization	Activity (such as PSE change, education, programmatic)
Senator Jeff Hayden	From sub workgroups understanding, has authored a bill to extend MA coverage to undocumented immigrants.
Voices for Racial Justice	Working on initiatives to address the "2nd class citizen" issue (e.g. driver's licenses for all)

Stakeholders for this issue not currently working on it and potential role:

Organization	Potential role (PSE change, education, programmatic)
MN Council on Latino Affairs	support legislation
Oncology programs/hospitals/CHCs	PSE change, to provide standard care to their EMA patients
MN Cancer Alliance Policy Committee	PSE change, support legislation

Strategies

Strategy #1: Promote legislative changes to EMA policy for cancer patients undergoing treatment and through at least 5 years of survivorship care.
Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy): Increase number of EMA cancer patients receiving equitable care to MA cancer patients
Rationale: EMA cancer patient should receive the same standard of care that MA cancer patients receive.
This is an _X___ evidence-based practice ____ promising practice ____ other. Please explain. In 2012, Minnesota implemented massive changes in requirements for coverage of low-income uninsurable patients (mostly undocumented immigrants) under EMA. Cancer is among a select few qualifying diagnoses that continue to receive coverage of outpatient visits and medications. Nonetheless, the 2012 changes—and subsequent 2015 enforcement modifications—have been incomplete and ill-informed, as illustrated below:

1. In late 2013, a pediatric oncology center, on behalf of one of its EMA patients, had to submit an appeal and extensive evidence in order to secure coverage of the outpatient maintenance chemotherapy drugs mercaptopurine and methotrexate for one of its patients with acute lymphoblastic leukemia. The review agency maintained that because the patient was "in remission," these medications were not life-saving and therefore not covered. In response, the oncology center submitted a copy of a study from the 1960's showing that 100% of patients who didn't receive maintenance therapy relapsed and died.
2. In 2015, EMA stopped covering the antibiotic Bactrim, used routinely to prevent pneumocystis pneumonia in immunocompromised patients, such as those undergoing chemotherapy. Additionally, coverage of outpatient antibiotics for the treatment of infection was eliminated unless providers could produce lab values indicating a specific infection. This same oncology center is currently appealing, citing a peer-reviewed paper outlining the "essential medications" for treating pediatric cancer.

Both of the above examples are easily recognized by practicing oncologists as substandard (flying in the face of documented knowledge about the minimum standard of treatment of cancer and management of potentially life-threatening complications in neutropenic patients), ill-informed (ignoring findings from over a half-century ago), and short-sighted (as both of these examples would surely lead to preventable hospitalizations and increased costs).

Of equal concern, EMA coverage abruptly ends when treatment is complete, ignoring the importance of early detection of relapses/recurrences and dismissing the importance of follow up surveillance and treatment of some of the damaging side effects of cancer treatment. Ineligible for coverage once chemo ends EMA cancer survivors are placed in the position of being denied follow up services and/or safety net providers swallow the financial burden of providing them on sliding scales. In the worst of cases, they pay with their lives.
Additionally, EMA denies coverage for important services such as physical therapy, psychological services, leading to a less "well" survivor who will likely suffer future consequences that will be treated in safety net facilities.

Lipman, Francine J. "Taxing undocumented immigrants: Separate, unequal and without representation." *Tax Lawyer, Spring* (2006): 06-20.
Roberts, William Mark, et al. "Measurement of residual leukemia during remission in childhood acute lymphoblastic leukemia." *New England Journal of Medicine* 336.5 (1997): 317-323.
Freireich, Emil J., et al. "The effect of 6-mercaptopurine on the duration of steroid-induced remissions in acute leukemia: A model for evaluation of other potentially useful therapy." *Blood* 21.6 (1963): 699-716.

Does this strategy promote health equity by addressing a racial, economic, geographic or other barrier? If yes, explain.
Yes, EMA recipients are largely low-income Latino undocumented immigrants with limited English proficiency, placing them unequivocally at risk for disparities in access to care, quality of treatment, and long-term health. Updating EMA coverage to be on par with coverage granted to other low-income Minnesotans is the right thing to do for health equity.

Rank this strategy for the greatest potential for traditional and non-traditional partners working together.
Rank ___ of ___ strategies

Strategy #2: Employ and educate navigators specialized in EMA applications, care plan certifications, and appeals

Indicator to measure progress (such as increased number of engaged stakeholders, increased media events, increased number of local jurisdictions that pass policy):

Rationale:

EMA cancer patient should receive the same standard of care that MA cancer patients receive. By employing and educating navigators that specialize EMA applications, care plan certifications, and appeals we are decreasing the barriers for EMA cancer patients in receiving equal standards of care and increasing access to care

This is an ____ evidence-based practice ____ promising practice ____ other. Please explain.

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Does this strategy promote health equity by addressing a racial, economic, geographic or other barrier? If yes, explain.

Yes, employing and educating navigators with a specialization in EMA application, care plan certifications, and appeals addressed barriers for EMA cancer patients in receiving equal standards of care and increasing access to care.

Rank this strategy for the greatest potential for traditional and non-traditional partners working together.

Rank ___ of ___ strategies