

Developing the Minnesota Cancer Plan

Step 1: Issue Analysis

Workgroup: **Treatment**

Date: May 2016

Issue Statement: The current level of coverage of cancer treatment under MN Emergency Medical Assistance (EMA) is substandard, ill-informed and shortsighted, leading to a 2nd class of cancer patients who are routinely denied access to essential aspects of standard cancer care and follow up services.

Describe the issue using public health data, peer reviewed research, or other evidence:

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.

What factors contribute to this issue? What racial, economic, geographic and other barriers contribute to this issue?

Undocumented immigrants are treated as 2nd class citizens in many aspects of U.S. life. Exclusion from state programs is largely based on the myth that they do not pay taxes. In fact, the opposite is true: every empirical study on the matter has concluded that undocumented immigrants contribute far more in taxes than they receive in social services.

What are the gaps in policy, systems and/or environmental services that give rise to this issue?

In the case of undocumented persons with cancer, Medicaid coverage is granted at a level that not only reinforces the 2nd class citizen status, but also places a moral and financial burden on the treating institutions. For the reasons outlined above, this policy's development lacks a critical analysis by professionals from the oncology field who could easily point out these discrepancies.

POLICY, SYSTEMS, and/or ENVIRONMENTAL (PSE) CHANGE: What are the policy, systems and/or environmental change opportunities to address this issue?

Policy: Update EMA coverage to match regular MA coverage

What strategies would you recommend to achieve PSE change?

1. Promote legislative changes to EMA policy for cancer patients undergoing treatment and through at least 5 years of survivorship care.
2. In the meantime, train and hire navigators specialized in EMA applications, care plan certifications, and appeals

HEALTH EQUITY: Which strategies promote health equity? Describe how they promote health equity.

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.

ALIGNMENT: Who are the partners already working on those strategies? What agencies and organizations should work together to address those conditions, gaps?

From what I understand, Senator Jeff Hayden has authored a bill to extend MA coverage to undocumented immigrants.

Organizations like Voices for Racial Justice are working on other initiatives to address the "2nd class citizen" issue (e.g. driver's licenses for all)

The MN Council on Latino Affairs would surely be willing to support legislation of this nature.

Oncology programs/hospitals/CHCs who have encountered the red tape and frustration trying to provide standard care to their EMA patients may be interested