

Policy in Clinical Practice: Emergency Medicaid and Access to Allogeneic Stem Cell Transplant for Undocumented Immigrants

Haley M Simpson, MD, PhD^{1*}, Allison Bock, MD¹, Lilia Cervantes, MD^{1,2}

¹Division of General Internal Medicine, University of Colorado School of Medicine, Aurora, Colorado; ²Division of Hospital Medicine and Office of Research, Denver Health, Denver, Colorado.

CLINICAL SCENARIO

Juan, a 50-year-old man with acute myeloid leukemia (AML), sat on the edge of his bed, dejected. Juan's leukemia had relapsed for a third time, and he was low on options and optimism. Originally from Mexico, he had made the journey to Colorado to work as a mechanic and care for his disabled son. Like millions of other individuals in the United States, he did not obtain a visa and had no affordable options for health insurance. For nearly a decade, that had seemed not to matter, until he became ill. Initially presenting to the emergency department with fatigue and night sweats, Juan was diagnosed with poor-risk AML and underwent emergent induction chemotherapy reimbursed under Emergency Medicaid (Table). Just when his bone marrow biopsy showed remission, however, Juan was told there was no chance to cure him, as his documentation status precluded him from receiving the next recommended therapy: stem cell transplant (SCT). Without transplant, Juan's leukemia relapsed within a few months. He decided to undergo all the salvage chemotherapy that was offered, worrying about how his son would survive without his father.

BACKGROUND AND HISTORY

For the patient with a new cancer diagnosis, a difference in immigration status may be the difference between life and death. Undocumented immigrants are excluded from federally funded benefits, including those offered under Medicare, most Medicaid programs, and the Patient Protection and Affordable Care Act (Table).¹ The nearly 11 million undocumented immigrants residing in the United States are integral to the workforce and economy. Although they pay taxes that fund Medicaid, contributing approximately \$11.7 billion nationally in 2017, undocumented immigrants are ineligible to benefit from such programs.² The inequity of this policy is highlighted by Juan, an undocumented immigrant presenting with a new diagnosis of AML.

The Emergency Medical Treatment and Active Labor Act (EMTALA) is a 1986 federal law which mandates that patients who present to the hospital with an emergency medical condi-

tion receive appropriate evaluation and stabilizing treatment. An emergency condition is defined as "manifesting itself by acute symptoms of sufficient severity ... such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy; (B) serious impairment to bodily functions; or (C) serious dysfunction of any bodily organ or part" (Table).^{3,4} The Centers for Medicare & Medicaid manual restates the EMTALA definition and notes that services for an emergency medical condition cannot include care related to organ transplantation. Most state Emergency Medicaid programs have adopted the federal definition of what constitutes a medical emergency.⁵ As a result, undocumented individuals who qualify for Medicaid benefits but who do not meet citizenship requirements are eligible to "receive Medical Assistance benefits for emergency medical care only."³

Similar to our patient Juan, individuals who initially present with an acute leukemia would be eligible for induction chemotherapy, as blast crisis is imminently fatal. Once in remission, however, standard-of-care therapy for patients without disqualifying comorbidities, depending on cytogenetic disease phenotypes, recommends the only current potential cure: allogeneic SCT, a treatment that was far from routine practice at the time EMTALA was enacted.⁶ When preparing for transplant, a patient is stable and no longer fits EMTALA's "emergency" criteria, even though their health is still in "serious jeopardy," as their cancer has been incompletely treated. Because most state Emergency Medicaid programs adopt the federal definition of an emergency medical condition, the cure is out of reach.

POLICY IN CLINICAL PRACTICE

This policy requires clinicians to deviate from the usual standard of care and results in inferior outcomes. For AML patients in the poor-risk category, allogeneic SCT is recommended following induction chemotherapy.⁷ The risk of relapse is 30% to 40% if consolidation therapy includes SCT, vs 70% to 80% if treated with chemotherapeutic consolidation alone.⁶ AML patients in the intermediate-, and sometimes even favorable-risk categories, have been shown to benefit from allogeneic SCT as well, with risk of relapse half that of a patient who undergoes consolidation without transplant. Undocumented individuals with AML are therefore resigned to inadequate cancer treatment, including lifelong salvage chemotherapy, and have a substantially decreased chance of achieving sustained remission.⁶ Furthermore, providing inequitable care for

*Corresponding Author: Haley M Simpson, MD, PhD;
Email: haley.simpson@cuanschutz.edu; Telephone: 303-724-0957.

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TABLE. Terminology and Acronyms

Term	Definition
Emergency Medicaid	State-level Medicaid policy providing uninsured patients who qualify for state Medicaid benefits but do not meet citizenship requirements with insurance coverage exclusively for emergency medical care.
Patient Protection and Affordable Care Act (ACA)	Comprehensive federal healthcare reform law enacted in 2010 to expand Medicaid and make affordable health insurance more widely available.
Emergency Medical Treatment and Labor Act (EMTALA)	A federal law mandating hospitals to provide evaluation and stabilizing treatment for emergency medical conditions regardless of the patient's insurance status or ability to pay. Emergency medical conditions are specifically defined as acute, severe symptoms threatening life or limb (also covers labor and delivery), but the law does not include coverage for follow-up care.

undocumented patients with other medical conditions, such as end-stage kidney disease (ESKD), has been associated with inferior patient-reported outcomes, higher mortality and hospital costs, and clinician burnout. In many states, undocumented immigrants with ESKD rely on emergency dialysis (dialysis made available only after presenting critically ill to an emergency department). In 2019, Colorado's Medicaid agency opted to include ESKD as a qualifying condition for Emergency Medicaid, thereby expanding access to scheduled dialysis. This led to improved patient quality of life, a decreased emotional toll on patients and clinicians, and reduced costs.^{8,9}

ECONOMIC CONSIDERATIONS

Policy discussions must consider cost. The average cost of allogeneic SCT in the United States was approximately \$226,000 in 2018, which is often compared to the cost of managing a patient with refractory disease who does not receive transplant.¹⁰ This study reported a cost of active disease without transplant, including chemotherapy and hospitalizations, of approximately \$69,000, plus terminal care costs of nearly \$89,000; at a total of \$158,000, this comes out to \$68,000 less than SCT.¹⁰ This cost savings, however, results in a patient's death rather than an up to 85% chance of long-term, relapse-free survival.⁶

To more completely capture the relationship between the healthcare value and cost-effectiveness of SCT, a second study calculated the incremental cost-effectiveness ratio (ICER) of transplantation in acute leukemias in the first 100 days post transplant, including management of complications, such as hospitalization, acute graft-versus-host disease (GVHD), infection, and blood product transfusions. ICER represents the economic value of an intervention compared to an alternative, calculated as cost per quality-adjusted life years. The ICER of SCT compared to no transplant is \$16,346 to \$34,360, depending on type of transplant and conditioning regimen.¹¹ An ICER of less than \$50,000 is considered an acceptable expense for the value achieved—in this case, a significant opportunity for cure. This finding supports SCT, including management of complications, as an economically valuable intervention. Furthermore, if a sustained remission is achieved with SCT, this difference in expense buys the individual patient potentially decades of productivity to contribute back into society and the economy. According to the National Bureau of Economic Research, undocumented workers as a whole contribute \$5 trillion to the US Gross Domestic Product over a 10-year period, or about \$45,000 per worker per year.¹² According to the costs cited, curing a single undocument-

ed worker with acute leukemia via SCT and allowing them to return to work would lead to a return on investment in less than 2 years. If the goal is high-quality, high-value, equitable care, it is logical to spend the money upfront and allow all patients the best chance for recovery.

One might suggest that patients instead receive treatment in their country of origin. This proposition, however, is often unrealistic. Latin American countries, for example, lack access to many standard-of-care cancer treatments available domestically. In Mexico, SCT is only available at a single facility in Mexico City, which is unable to track outcomes.¹³ The mortality-to-incidence ratio for cancer, a marker of availability of effective treatment, for Latin America is 0.48, substantially inferior to that of the United States (0.29).¹⁴ Importantly, almost two thirds of undocumented immigrants in the United States have lived in the country for 10 or more years, and 43% are parents of minor children, an increasing proportion of whom are American citizens.¹⁵ This highlights the impracticality of these individuals returning to their country of origin for treatment.

COMMENTARY AND RECOMMENDATIONS

Medicaid laws in several states have made it possible for undocumented immigrants to receive access to standard-of-care therapies. Washington and California have included provisions that enable undocumented immigrants to receive allogeneic SCT if they are otherwise medically eligible. In the course of this policy change, legal arguments from the California Court of Appeals expressed that the language of the law was not intended to deny lifesaving treatment to an individual.¹⁶ California's Emergency Medicaid policy is comparable to that of other states, but because the courts considered SCT a "continuation of medically necessary inpatient hospital services ... directly related to the emergency" for which the patient initially presented, they concluded that it could be covered under California Medicaid. Despite covering SCT for undocumented immigrants, California maintains lower costs for those patients compared to US citizens on Medicaid while providing evidence-based cancer care.¹⁷ This exemplifies sustainable and equitable healthcare policy for the rest of the nation.

A proposed change in policy could occur at either the federal or state level. One option would be to follow the example set by the State of Washington. Under Emergency Medicaid, Washington modified qualifying conditions to include "emergency room care, inpatient admission, or outpatient surgery; a cancer treatment plan; dialysis treatment; anti-rejection medication for

an organ transplant” and long-term care services.¹⁸ Federal policy reform for undocumented immigrants would also improve access to care. The US Citizenship Act of 2021, introduced to the House of Representatives in February 2021, offers a path to citizenship for undocumented immigrants, ultimately allowing for undocumented individuals to be eligible for the same programs as citizens, though after a period of up to 8 years.¹⁹ More immediate revisions of qualifying conditions under state Emergency Medicaid programs, coupled with a path to citizenship, would make significant progress towards reducing structural health inequities.

Such policy change would also have broader implications. Three quarters of undocumented immigrants in the United States originate from Mexico, Central America, and South America, and the incidence rate of AML for Latinx individuals is 3.6 per 100,000, a figure which can be extrapolated to an estimated 380 cases per year in the US undocumented population.²⁰⁻²² In addition to benefiting patients with acute leukemias, the proposed policy change would also benefit numerous others who are frequently hospitalized for acute decompensations of chronic conditions, including congestive heart failure, liver disease, ESKD, and chronic lung conditions. Enabling follow-up care for these diseases under Emergency Medicaid would likewise be expected to reduce costs and improve both quality of care and patient-centered and clinical outcomes.

WHAT SHOULD I TELL MY PATIENT?

Hospitalists frequently care for undocumented immigrants with acute leukemias because the hospital can only be reimbursed by Emergency Medicaid when a patient is admitted to the hospital. Patients may ask about what they can expect in the course of their illness and, while details may be left to the oncologist, hospitalists will be faced with responding to many of these questions. Clinicians at our institution hold honest conversations with patients like Juan. We are compelled to provide the care that hospital and state policies allow, and can only offer the best care available to them because of the restrictions of an insurance system to which they contribute financially, yet cannot benefit from, in their time of need. We can tell our undocumented immigrant patients that we find this unacceptable and are actively advocating to change this policy.

CONCLUSION

The State of Colorado and the nation must amend its health-care policy to include comprehensive cancer care for everyone. Offering standard-of-care therapy to all patients is not only ethical, but also an economically sound policy benefiting patients, clinicians, and the workforce.

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