CARE IN THE SHADOWS

THE CHALLENGES FOR UNDOCUMENTED IMMIGRANTS

By Carmen Peota

THE MAN, MIDDLE-AGED AND AN IMMIGRANT FROM MEXICO, HAD CHEST PAIN.

It wasn’t the first time, and this episode was more severe than the last. Christopher Reif, MD, a family physician at Community University Health Care Center (CUHCC), was worried. “When somebody has a big change in something like chest pain, you have to think seriously, do they have an impending heart attack coming?” he says.

Reif ran the tests he could at CUHCC, then recommended that the man go to the ER for a full cardiac workup. It was what any good doctor would do. But the patient said he’d just go home, take his medicine and take it easy. Although he had a job, he didn’t have health insurance and couldn’t afford the charges he might incur.

The decision seemed risky to Reif, who thought his patient needed stress testing and perhaps even cardiac catheterization. “It’s very frustrating to me to know exactly what someone needs—and to be able to offer them the best standards of care—and it turns out they can’t afford the medicine or testing,” he says.

Reif didn’t ask the patient about his immigration status—he never does; but when he learned the man didn’t have health
insurance, he was pretty sure the reason was his immigration status. Reif wondered if he might qualify for Emergency Medical Assistance (EMA). But would his condition be considered an emergency?

Undocumented and with needs that were greater than a primary care doctor could meet, the patient had fallen into one of the remaining holes in the health care system.

**CRISIS MANAGEMENT**

Health insurance is out of reach for most of the 95,000 or so undocumented immigrants living in Minnesota. Most earn too little to afford the cost of premiums in the private market, and most government programs and supports are off-limits.

Without insurance, they seek out low-cost or free care at Federally Qualified Health Clinics (FQHCs) like CUHCC, rural health clinics and charity care providers. They might take generic medications that are on the $4 lists at local pharmacies or drugs obtained through a pharmaceutical company’s assistance program. They might share medications with family members who have insurance. Or they might forego care altogether.

If they break a bone or have chest pain, they *might* be eligible for EMA, which covers care for acute symptoms (including pain) and conditions so severe that without immediate (typically within 48 hours) medical treatment, the patient’s health might be in serious jeopardy or bodily functions and organs or parts might be damaged. Examples of such conditions listed on the Department of Human Services website include stroke, heart attack, abscessed teeth, broken bones, ear infections and kidney failure. Among the longer list of things EMA does not cover are preventive care, prescription medications, home care and immunizations.

“It’s very different than if they had Medicaid or Medicare or if they had private insurance,” Reif says. “For people who don’t have insurance, whether citizens or not, it’s really a burden to their health and a burden to us as health care deliverers.”

The real difficulties come when, like Reif’s patient, someone needs more than primary care but less than emergency care. Veronica Svetaz, MD, MPH, an adolescent medicine specialist at Whittier Clinic in Minneapolis, sees how this plays out all the time. One of her patients has a chronic digestive condition, and Svetaz has tried, but thus far been unable, to get her specialty care. In the meantime, the young woman’s condition is out of control, and she ends up in the hospital when it flares. “[EMA] will cover the admission, but in between nothing,” Svetaz says. “So we go from one crisis to another.” Another patient with depression has been hospitalized three times for suicide attempts. EMA covers her hospitalizations, but once she’s discharged, she’s on her own, with no opportunity for intensive, ongoing outpatient treatment, which Svetaz says she desperately needs. “It’s like we’re making sure the patient with a severe condition is always in the hospital,” she says.

**UPSIDE-DOWN APPROACH**

Getting undocumented immigrants into specialty care has become more difficult in recent years for a number of reasons. One is the Affordable Care Act. Since its passage, programs that were in place to help the uninsured, such as pharmaceutical company assistance programs, have dried up because there’s an assumption that people have insurance.

Another is that federal funding of EMA was scaled back in 2011. Before, it would cover some services provided in an ambulatory setting—services that might keep someone out of the hospital. Now it covers only care provided in the ER or hospital.
“In my opinion, it’s upside down,” says Jonathan Watson, director of public policy for the Minnesota Association of Community Health Centers. “We should be trying to prevent emergency conditions in these populations regardless of their immigration status. And from a cost perspective, a health center can provide one patient encounter for roughly $250. I’m sure that’s a lot cheaper than for the ER doors to open even one time.”

In 2015, a Health Care Financing Task Force convened by Gov. Mark Dayton recommended extending MinnesotaCare benefits to uninsured, low-income individuals ineligible for Medical Assistance and other state programs because of their immigration status. That idea hasn’t moved forward. Detractors cite its cost, estimated at $70.3 million. Watson says that amount doesn’t reflect the savings that could be had by providing care that could prevent hospitalizations.

**THE COMPLICATED ORDINARY**

For physicians, finding specialty care for undocumented immigrants has become sort of a specialty in itself. That’s the case for Jennifer Rho, MD, MPH, an internal medicine physician who sees patients at a Community Health Service Inc. clinic in Rochester. Formerly Migrant Health Services, the organization serves many people working in agricultural industries. To get her patients what they need, Rho says she taps into the network of safety-net providers and specialists she knows in the Rochester area, sometimes trading services. For example, her clinic allows a local charity clinic to send over patients for lab work. In return, she’ll ask them to call her when a cardiologist is volunteering at their clinic so she can send her patient over there. “It’s a lot of piecemealing things together,” she says.

Working that way can get complicated. Rho recently saw a 47-year-old man with diabetes who has eye damage. She referred him to a free clinic, where he was seen by an ophthalmologist. The free clinic got him into a hospital, where he underwent a procedure. But when he tried to get follow-up care, he was turned down. “Now we’re trying to get him EMA so he can get back to the same hospital for more treatment for his eyes,” Rho says, hoping to save his vision. If he does get EMA coverage, it will be for three to six months, during which time Rho will also try to get care for the nerve damage in his feet and a urological problem. “He might get EMA approved, but it actually might expire before he gets all the tests and referrals done,” she says.

In addition to piecing together care for patients, Rho is always thinking about the cost of care. For example, she mostly prescribes medications she knows patients can buy for $4 at a pharmacy. If a patient needs screening for colon cancer, she’ll recommend a fecal occult blood test, which costs only a few dollars, instead of a colonoscopy, which can cost thousands.

Svetaz says a big part of her job is maximizing what can be done through existing systems. For example, knowing that she can get two months of coverage through Medicaid for a teen for family planning, she’ll recommend an IUD, which will give the woman three to five years of protection. “It’s being aware and knowledgeable and having strategies,” she says.

Those who care for undocumented immigrants know that some may wonder why physicians should provide any care at all to people who have arrived in this country without visas or work permits. Many, like their patients, tend to shy away from the limelight and the political discussions about immigration. Rho’s response to those who wonder why she does what she does is simple: “As physicians, it’s not our job to make judgments about why people are here or if they should be here. It’s our job to take care of patients.”

Carmen Peota is a freelance writer in Minneapolis.

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**WHO ARE THE UNDOCUMENTED IN MINNESOTA?**

The population is estimated at between 80,000 and 95,000 individuals. The majority are from Mexico and other countries in Central America. Half have lived in the state 10 or more years.

Almost by definition, they are the working poor. Two-thirds work in industries such as agriculture, hospitality, entertainment and manufacturing. For a third of families, incomes are below 100 percent of federal poverty levels. Incomes are between 100 and 200 percent of poverty for another third.

Many immigrants have mixed-status families. Some members may be citizens and eligible to purchase insurance through MNsure or to be covered under Medicaid or CHIP, while others may be undocumented and thus ineligible for these programs.

Source: Migration Policy Institute, Pew Institute Foundation, U.S. Centers for Medicare and Medicaid Services