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State Flexibility in Emergency Medicaid to Care for Uninsured Noncitizens

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Viewpoint

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Emergency Medicaid (EM) is a crucial but often overlooked safety net for lower-income, uninsured noncitizens who are ineligible for public health insurance because of their immigration status. Substantial state-by-state variation exists in emergency medical conditions considered reimbursable under EM. For example, some states consider end-stage kidney disease (ESKD) to be an emergency medical condition and provide routine hemodialysis under EM, while other states consider ESKD as an emergency medical condition only when a patient becomes critically ill and requires emergency hemodialysis. During the pandemic, not all states defined COVID-19 and related sequelae as emergency medical conditions, further deepening the disparities in access to care for uninsured noncitizens across states. As Medicaid flexibilities linked to the COVID-19 public health emergency come to an end, and as state Medicaid programs begin to reevaluate existing coverage pools, it is imperative that states consider the authority they have to define conditions reimbursable under EM.

Although it is difficult to estimate a precise number, between 11 and 14 million noncitizens living in the US are excluded from federal health insurance programs (including Medicaid and Medicare) under provisions of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[1] Some noncitizens who are considered lawfully present may purchase subsidized insurance from the exchanges established by the Affordable Care Act. However, all undocumented noncitizens are ineligible for federal insurance affordability programs.

Emergency Medicaid reimburses treatment of emergency medical conditions for uninsured patients who are excluded from Medicaid because of their immigration status. An emergency medical condition is statutorily defined as "manifesting itself by acute symptoms of sufficient severity (including severe pain) 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." Often, EM reimburses treatment provided to patients under the Emergency Medical Treatment and Labor Act, which requires hospitals that accept Medicare and provide emergency services to treat patients with emergency medical conditions, regardless of their immigration status or ability to pay, until they are stabilized. However, EM is not limited to reimbursing treatment provided in hospital emergency departments.

States have discretion in how they administer EM and interpret the definition of qualifying conditions. While some states allow individuals to apply in advance of treatment, other states only approve applications for treatment that has already occurred (eg, stabilizing care provided in an emergency department). Applicants in states that fall in the former category, such as New York, can obtain treatment for serious health conditions in outpatient settings rather than in hospital emergency departments. In such states, it is easier to approve EM for treatment for conditions, such as cancer care and routine dialysis.[2,3] The consequences of this administrative decision are substantial, as studies have demonstrated not only that scheduled outpatient care is associated with improved health outcomes in ESKD patients[4] but also that expenditures associated with outpatient care are significantly lower than those associated with emergency care.[5]

The Centers for Medicare & Medicaid Services (CMS) generally defers to states' interpretations of emergency medical conditions without requiring a Medicaid state plan amendment or other formal policy action. Indeed, CMS has clarified that the federal statute provides substantial leeway for states to define qualifying conditions. As the year-long Medicaid unwinding period begins, states are

reevaluating eligibility criteria, seeking waivers to implement new renewal methods, and providing pathways to other forms of coverage. In this context, states should maximize the use of EM to help meet the critical health care needs of undocumented noncitizens, who may have greater disease burden from chronic conditions, such as cancer, due to their exclusion from federal insurance affordability programs.[3]

State Medicaid programs should consider expanding their interpretation of qualifying conditions to access additional federal funding to treat noncitizen residents who are excluded from Medicaid.[2,3] For example, during the COVID-19 pandemic, 12 states issued guidance through their Medicaid programs affirming that COVID-19-related testing and treatment services are reimbursable by EM.[6] This policy action helped to ensure that noncitizens excluded from public health insurance could have access to free COVID-19 testing and treatment.

State Medicaid programs should also consider publicizing the qualifying conditions that they have already recognized to spread awareness about the availability of EM coverage. This could be done in various ways, including by incorporating the list of routinely approved emergency medical conditions into policy guidance documents. For example, the Pennsylvania Department of Human Services issued an Operations Memorandum in July 2022 listing qualifying conditions that may be approved at the county level without further evaluation by the agency's clinical advisors. The listed conditions include high-risk pregnancy, type 1 diabetes, cancer requiring active treatment, and acute inpatient psychiatric hospitalization, among others. The list appears on the form that physicians, physician's assistants, or certified nurse practitioners must submit on behalf of applicants of EM, eliminating ambiguity about whether those conditions qualify for treatment. If adopting this approach, states should make clear that the list of routinely approved emergency medical conditions is not exclusive; other conditions may qualify if they meet the federal statutory definition.

States that adopt an overly narrow interpretation of emergency medical conditions or that do not publicize routinely approved conditions forgo federal funds for the care of noncitizens who, without treatment, are at risk of serious health consequences.[1] Emergency Medicaid supplements state budgets even in states, such as California and New York, that have established subsidized health insurance for noncitizens excluded from federal programs.[7] State flexibility in EM presents compelling opportunities to innovate and fund expanded access to health care for uninsured, lower-income, Medicaid-ineligible noncitizens.

When states take advantage of EM flexibility to expand access to health care for noncitizens, the benefits extend beyond the individuals whose treatment was reimbursed. Studies demonstrate that inclusive state health policies are associated with both health insurance status and health care utilization patterns of noncitizens' US-born children.[8,9] In addition, uninsured, lower-income US citizens with serious health conditions who do not meet the income eligibility criteria for Medicaid—particularly in states that have not expanded Medicaid under the Affordable Care Act—may also rely on EM.

Joint advocacy by legal and health care professionals can help to persuade state Medicaid officials to broaden their interpretation of emergency medical conditions. For example, in Colorado, an interprofessional coalition of stakeholders successfully advocated for the state to recognize ESKD as a qualifying condition.[10] When states expand their interpretation to include conditions that are routinely reimbursed by EM in other states, they are unlikely to provoke a challenge from CMS. Explicit guidance from CMS affirming that it affords broad discretion to states to define emergency medical conditions would offer additional assurance. As legislative proposals to expand subsidized health coverage for noncitizens are considered at the federal and state levels, EM offers an immediately available pathway for states to improve access to care for uninsured, lower-income noncitizens with serious health conditions.

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