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NKF, ASN Recommend State Medicaid Changes to Allow Coverage of Scheduled Dialysis for Undocumented Patients

By Bridget M. Kuehn

It's a week-to-week challenge for Eric Wallace, MD, and his colleagues to treat patients with end stage kidney disease (ESKD) who are undocumented immigrants. Many are young people in their 20s and 30s who are working or in school; one recently was pregnant. They are not eligible for coverage under Medicare and cannot buy coverage through the Affordable Care Act on state exchanges. If they cannot buy private insurance, their only option for care is emergency dialysis, which is covered by the Emergency Medical Treatment and Active Labor Act (EMTALA).

"All of us are hoping and praying they make it to their next treatment," said Wallace, who as medical director of home dialysis at the University of Alabama at Birmingham frequently cares for undocumented Latinx patients. He worries that a patient may have an emergency between visits and wait too long to seek help. The situation is especially heart-breaking for Wallace, whose mother came to the United States from South America as an undocumented immigrant at 18 years old and later became a citizen.

"We are treating one set of human beings differently, and they are young and exactly like my mom when she came over," Wallace said. "You get patient and provider burnout because we are providing substandard care."

Emergency dialysis also contributes to worse outcomes for the estimated 5000 to 7000 undocumented patients with kidney failure in the United States (1) and is about 4 times more costly than scheduled dialysis (2). These costs are paid for by the hospital or state Medicaid programs. To reduce these burdens, at least 12 states have already expanded their Emergency Medicaid programs to cover scheduled outpatient dialysis for this vulnerable group of patients (3). In August 2021, the ASN signed on to a letter from the National Kidney Foundation (NKF) urging more state Medicaid directors to make this change as well as to cover home dialysis.

"The kidney care these individuals receive is inhumane, extraordinarily expensive, and largely ineffectual," the NKF

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Does Nephrology Need *U.S. News & World Report* Rankings?

By T. Alp Ikizler and Beatrice Concepcion

Annually, *U.S. News & World Report* (*USNWR*) publishes a ranking of the best hospitals in the United States by adult specialties. According to the *USNWR* website, the aim of these rankings is to provide a tool for patients with life-threatening or rare conditions that would help them find skilled inpatient care at a hospital that excels in treating complex, high-risk cases (1). Hospitals are ranked from 1 to 50 in each specialty, and any hospital in the top 10% of all rated hospitals (but not ranked in the top 50) is given a "high performing" designation (1).

In addition to ranking hospitals by specialties, *USNWR* also rates hospitals on their performance of procedures and treatment of specific conditions. Hospitals are rated as high performing, average, or below average for each specific procedure and condition. Based on the cumulative performance in specialty rankings and procedures and conditions, the Best Hospitals Honor Roll recognizes the nation's top 20 hospitals. In 2020–2021, a hospital's overall score partly came from rankings of 12 "data-driven" specialties (including nephrology) comprising components for patient experience (patient surveys, 5%), discharge-to-home metric (7.5%), reputation

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letter states. "Our organizations believe it is imperative that state policymakers act expeditiously to follow the lead of states like Arizona and Colorado and expand Emergency Medicaid for undocumented immigrants living in the United States."

"Gut wrenching"

When Oanh Nguyen, MD, assistant professor in the Division of Hospital Medicine at the University of California—San Francisco, started seeing patients as an intern at Parkland Hospital in Dallas, she was shocked to learn that patients with ESKD who were undocumented immigrants received emergency dialysis instead of scheduled dialysis. She had gone to medical school in California where the state's Medicaid program covers scheduled dialysis for this vulnerable population and described what she saw during her residency and later as a member of faculty as "gut-wrenching."

"These were good, honest, hardworking people just trying to support their families," Nguyen said. "They were just so grateful to be receiving any care, but it was hard to be face-to-face with them knowing that this is not the type of care they should be receiving."

As a resident at Indiana University in Indianapolis, Areeba Jawed, MBBS, assistant professor of medicine at Wayne State University in Detroit, saw the difference that scheduled dialysis can make for these patients. The safety net hospital she was interning at initially offered scheduled dialysis as charity care to undocumented immigrants, but a change in leadership led to the decision to switch to emergency dialysis. As a result of the policy change, she and her colleagues saw a decline in patients' health. One young man wanted to do his emergency dialysis on the weekends to continue working during the week to support his family. But like many patients on emergency dialysis, he lost residual kidney function over time.

"We saw him deteriorate to the point that he just couldn't survive without dialysis between Monday and Friday; he couldn't continue to work," she said. Jawed's experience is now backed by a growing evidence base showing emergency dialysis leads to poor outcomes and is less cost effective than scheduled dialysis for these patients.

When a change in national policies allowed some of Nguyen's patients who were undocumented to purchase private insurance in 2015, she used it as an opportunity to compare outcomes and costs for the patients who were able to begin scheduled dialysis covered by private insurance with those who remained on emergency dialysis (4). She found that the 1-year mortality rate for patients who remained on emergency dialysis was 17% compared with just 3% among the patients who switched to scheduled dialysis. The patients on scheduled dialysis had six fewer emergency department visits a month and spent 10 fewer days in the hospitals for every 6 months. This translated to $5700 less in healthcare costs per month, or about $70,000 per year for the scheduled dialysis patients.

A retrospective study led by Lilia Cervantes, MD, associate professor of hospital medicine at the University of Colorado School of Medicine, comparing outcomes among 211 undocumented patients who received scheduled dialysis in California or emergency dialysis in Texas or Colorado, found 14 times higher 5-year mortality among those receiving emergency dialysis (5). The patients receiving emergency dialysis also required 10 times more days of acute care than those receiving scheduled dialysis. Patients also report experiencing extreme physical and psychological distress, often feeling like they are drowning or can't breathe as they accumulate fluids between visits (6).

"Patients described death anxiety, feeling that they didn't know if they would live from week to week," Cervantes said. It can also have a devastating effect on families. A young mother named Hilda, who Cervantes cared for, with two school-aged children experienced three heart attacks causing distress for her children (7). Hilda eventually found a family to adopt her children and chose to end dialysis and pursue palliative care until she passed away.

Seeing these outcomes and feeling unable to provide better care cause moral distress for many clinicians. A survey of clinicians at a safety net hospital in Indianapolis, Indiana, found that almost three-quarters experienced distress over patients suffering because of inadequate dialysis (8). Another study of clinicians caring for these patients also reported high levels of moral distress, burnout, and frustration over this poor use of health resources (9).

"It puts physicians in a position where we feel helpless and inhumane," Wallace said.

Moving the needle

Hilda's case inspired Cervantes and her colleagues to study this issue and push for a change in Colorado's Medicaid policies. Colorado made the change to its policies in 2019, which is expected save the state $17 million a year (10). It also has led to dramatic improvements in patients' health and quality of life (6). She said support from national organizations like NKF and ASN for more states to make this change may help further "move the needle."

There was a clear consensus among the members of the ASN Quality Committee to support signing on to the letter, said the committee's chair, Scott Bieber, DO, a nephrologist at Kootenai Health in Coeur D'Alene, Idaho. Bieber, who has practiced in states with and without Medicaid coverage for scheduled dialysis, said there is a stark difference in the quality of care patients receive.

"[Scheduled dialysis] is the right thing to do to keep patients healthy," Bieber said.

The NKF-ASN letter also advocates for coverage of home dialysis. Wallace, who is also a member of the ASN Quality Committee and a Medical Director of Home Dialysis, said home dialysis in particular may help improve patients' quality of life by enabling them to continue with school or work. He called the letter "a first step" and said he'd like to go further to offer transplant as well. Bieber noted that many other committee members shared that sentiment.

"As the data illustrate, the manner in which undocumented people with kidney failure are treated is needlessly expensive," the letter states. "At a time when states' budgets are under enormous pressure, ensuring that undocumented people with kidney failure can access Emergency Medicaid is just common sense."

There are also potential cost savings for hospitals that may have to cover the costs of emergency dialysis. In her study, Nguyen estimated that switching all undocumented patients from emergency dialysis to scheduled dialysis would save Parkland Hospital $13 million a year. The study inspired the hospital to change its policy and work with outpatient dialysis providers to provide scheduled dialysis for undocumented patients, she said. Now, they are piloting home peritoneal dialysis, which may further reduce costs and improve patients' quality of life. Nguyen acknowledged there are challenges in reliably estimating potential cost savings. But she said evidence from California suggests that contrary to some opponents' fears, allowing coverage for scheduled dialysis does not lead to an influx of undocumented patients seeking dialysis.

"Scheduled dialysis should be the universal standard of care for everyone," she said. "There is really no reason to withhold that standard of care from an ethical or even an economical standpoint."

Additionally, offering scheduled outpatient dialysis allows hospitals to more effectively deploy their resources to serve their entire communities, Nguyen said. Jawed said this is particularly important now in the face of the pandemic. Requiring undocumented patients with kidney failure to come into the emergency department for dialysis increases their risk of becoming infected as well as adds to the burden of already overwhelmed clinicians and facilities running short on beds, said Jawed, who documented the disproportionate toll COVID-19 has taken on undocumented patients with ESKD in a recent *Kidney News* article (11). She noted that undocumented immigrants are often frontline workers and may live in crowded housing, increasing their risk of infection.

Jawed said that while physicians may not ultimately make the decision about what policies to enact, they have a role to play in shaping policies. She noted they can help by recognizing the contributions that undocumented immigrants make to our communities whether through the jobs they do or the taxes they pay. They can also make decision-makers aware of how policies are affecting patients, clinicians, and care systems.

"This is an area where not just nephrologists but all clinicians can really come together in solidarity and advocate for a very vulnerable or marginalized population," Cervantes said. ■

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