in the direction of accountable care organizations. On the question of “economies of scale,” she thinks the jury is still out.

Medicaid expansion and end stage renal disease

Amal Trivedi, MD, MPH, associate professor of health services, policy and practice, Brown School of Public Health, publicly released his study “The Affordable Care Act, Medicaid Expansion, and End-Stage Renal Disease” concurrently during his talk at the session and with the Journal of the American Medical Association nationally. Before the Affordable Care Act (ACA), one-fifth of undocumented adults were uninsured at the time they began dialysis.

Trivedi presented that “among the broader population, there is an emerging body of evidence on the effects of Medicaid expansion:

• Gains in coverage,
• Improved access to care,
• Increased use of preventive services, and
• Better self-rated health.

The study aimed to measure the impact of ACA-Medicaid expansion on these factors:

• Insurance coverage at time of dialysis initiation,
• Predialysis nephrology care, and
• 1-year mortality for nonelderly patients with ESRD who begin dialysis.

The study used a quasieperimental difference-in-differences analysis to examine the change in outcomes among new dialysis patients in Medicaid expansion states compared with nonexpansion states. It also included all patients in the United States aged 19 to 64 who began dialysis from the beginning of 2011 through the end of March 2017, excluding patients with Medicare coverage (including duals) and those with Veterans Administration (VA) coverage, inasmuch as the ACA coverage expansions would not apply to them, although they were included in a sensitivity analysis. This resulted in an analytic sample of over 236,000 patients.

Our primary outcome was all-cause mortality over the 1-year period that began with the 91st day after dialysis initiation,” Trivedi said. “We used this definition of mortality because deaths among incident dialysis patients are not reliably reported within the first 90 days following dialysis initiation (this follows the United States Renal Data System approach). Additionally, only patients who initiated dialysis before January 1, 2016, were included for the mortality outcome to allow for follow-up (180,044 patients).”

The study also examined insurance coverage at the time of dialysis initiation, focusing on Medicare coverage and being uninsured. It then looked at receipt of predialysis nephrology care. First, the study examined whether the patient had received care from a nephrologist before beginning dialysis and whether the patient had a fistula or graft during their first treatment session. The two nephrology care measures are tracked as part of the Healthy People 2020 goals for chronic kidney disease. The study used both statistical analyses and sensitivity analyses.

Figure 1 shows unadjusted 1-year mortality for patients beginning dialysis. Before expansion, mortality rates were nearly identical in expansion states (dashed black line) and nonexpansion states (solid red line). After expansion, the mortality rate in non-expansion states remained the same, but the mortality rate in expansion states declined after Medicaid expansion was enacted.

Trivedi concluded, “To sum up, the ACA’s Medicaid expansion was associated with improved insurance coverage, access to care, and survival among nonelderly ESRD patients initiating dialysis. This supports the idea that the health effects of insurance coverage are likely greatest for patients with severe health conditions.”

Caring for the Most Vulnerable Of Vulnerable Patients: the Undocumented ESRD Population

By Mukta Baweja

Immigration. One of the most polarizing issues in the country was the topic of a special session devoted to Improving Care for Vulnerable Patients at ASN Kidney Week 2018. Speakers included Rajeev Raghavan, MD, FASN, associate professor of medicine/nephrology at Baylor College of Medicine; Valerie Layoux, MD, Institute of Biomedical Ethics, Geneva, Switzerland; Lauren Stern, MD, assistant professor of medicine and nephrology at Boston University; and Jenny Shen, MD, assistant professor of medicine and nephrology at UCLA.

Understanding the issues surrounding the care of undocumented patients begins with numbers. ESRD patients account for <1% of the Medicare population, yet they account for 7% of the Medicare budget, at a cost of $38 billion per year (2018). There are approximately 11 million undocumented immigrants in the United States. By a conservative estimate, 6500 of these undocumented immigrants suffer from ESRD (1) out of about 700,000 ESRD patients nationwide, so approximately 1% of our ESRD patients are undocumented.

And there is a geographic propensity as well: just 4 states account for about 50% of the undocumented population with ESRD: California (24%), Texas (14%), Florida (9%), and New York (8%). Of these 4 states, only 2—California and New York—offer chronic outpatient hemodialysis therapy using nonfederal funds as treatment options for the undocumented.

Although undocumented immigrants make up a small proportion of our patients, over 60% of nephrologists report that they have provided care to the undocumented and note rising prevalence, with most also reporting inadequate compensation that jeopardizes the long-term availability of treatment to the undocumented population (2).

Providing care to those without clear access to care is not without its burden. Understanding the social circumstances of a patient and the degree of their illness and suffering without sufficient means to help is an ethical and emotional dilemma. To quote Nathan Gray, MD, a palliative care physician and graphic narrator who recounts the patient experience: “I wish he’d had a better death, but more than that, I wish he’d had a better life.” (3).

Undocumented immigrants are more likely to be uninsured than legal immigrants and US citizens (4). And, since they are ineligible for federal services such as Medicare, full scope Medicaid, and the provisions under the Affordable Care Act, the only method for treatment is afforded under the Emergency Medical Treatment and Labor Act (EMTALA), or modified emergency Medicaid in some states, local funds, off-exchange insurance programs, and possibly third-party payers. Other states offer emergency-only dialysis, an extremely resource-intensive, expensive treatment with considerably higher mortality than standard hemodialysis.

Emergency dialysis

Emergency-only dialysis entails just that: dialysis only in cases of emergency after an ER visit, when there are significant symptoms or instability and hyperkalemia. Even without data, this practice already would presume to be associated with significant ethical and moral dilemmas. Consider a patient who is younger, a member of the workforce, and must tolerate the symptoms of end stage kidney disease until a near-death emergency permits them to receive treatment, only to then wait in the emergency room for several hours, perhaps while they have young children waiting for them at home. Then imagine them perhaps repeating the same sequence of events soon afterward.

Our study isn’t working. So what do we do to fix it? What are the next steps? We advocate. We educate. We demand a national policy for ESRD in the undocumented population.

Our system isn’t working. So what do we do to fix it? What are the next steps? We advocate. We educate. We demand a national policy for ESRD in the undocumented population.
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harm, and it really seems that we are doing harm with these practices.”

Transplantation

Transplantation, which is excluded from EMTALA, has lower mortality, better quality of life, and is more cost effective. Although there is no legal barrier to transplantation in the undocumented based on the National Organ Transplant Act of 1984, there is an effective barrier—particularly financially for those without insurance coverage—owing to concerns about ability to afford not just the transplant, but posttransplant medications and the associated social circumstances. By contrast, there are no barriers to organ donation based on citizenship status, so the undocumented can contribute to the organ pool, but have significant limitations to benefit from it.

In 2014, Illinois became the first state to list undocumented patients for kidney transplant. The rationale behind this move was based not only on ethics, but also on economics: for Illinois, transplant is the cheaper option to slow the progression of CKD. The presentation reviews clinical data on the use of low protein diets with keto-analogues as a therapeutic option to slow the progression of CKD. The counterargument to listing undocumented immigrants for transplant is the perception that they would not do as well as citizens given their circumstances, access to medications, and care—and may be deported where the access to care may even be worse. However, Shen and colleagues conducted a study comparing a group of US citizens and permanent residents to the undocumented and found that undocumented immigrants actually had a greater graft survival rate when results were unadjusted. And no increased rate of graft loss was observed when the findings were adjusted for demographics, comorbid conditions, dialysis, and transplant-related factors (9).

Politics and kidney care

There are other, more politically minded arguments against having undocumented immigrants become transplant recipients. One of the arguments concerns supply and demand.

If there are over 100,000 patients on the transplant waitlist with only 12,000 patients being transplanted per year, is it fair to allow undocumented patients in the pool to increase the waitlist size? Shen and colleagues also found that undocumented patients were more likely to have a living donor (60%), and the addition of undocumented patients increased the waitlist by only 3% (9).

Additionally, if these individuals add to the donor pool by donating organs when they die, is it fair for them to not be able to receive an organ if needed? If transplantation is cost-effective and living donors are more available for this population, wouldn't this be potentially low-hanging fruit to help save and improve lives while cutting costs?

Taxpayer funding of healthcare for the undocumented is controversial, to say the least. However, it should be noted that undocumented immigrants contribute nearly $12 billion in taxes, with $2.4 billion directed toward Medicare (9). They also generate a surplus in the magnitude of billions in Social Security programs, and from 2000 to 2011, generated a $35.1 billion surplus in the Medicare Trust Fund (10).

They also have a very high rate of employment: 94% are employed, and they make up about 5% of the total civilian labor force (11). Yet, when they are subjected to emergency-only dialysis, the employment rate drops significantly from ~90% to about 14% due to the burden of illness and the irregularity of their schedule given their dependence on care (5). Regardless of stances on immigration status, being sick and having access to suboptimal care would appear to result in a significantly increased financial burden than would having access to more standardized treatment options.

Our system isn’t working. So what do we do to fix it? What are the next steps?

We advocate. We educate. We demand a national policy for ESRD in the undocumented population (12). We ask that we be able to treat the sick as equal, and by ethics, we should not be obligated to restrict care based on citizenship status.

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