Outline

- Introduction
- The Current Political Environment and Latinx Demographics
- Portrait of Undocumented Immigrants in the United States
- Estimate of Undocumented Immigrants with ESRD
- Health Care Options

Outline

- Difficult Choices: Treatment Options in the United States and the role of Emergency Medicaid
- Call to Action/ Evidence Based Solutions
- Success Stories: The role of advocacy and policy
- Summary

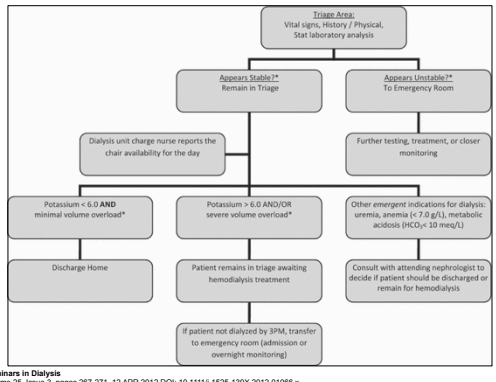
Undocumented Immigrants and ESRD

- Seattle, Washington
  - What does the future hold for an uninsured, undocumented patient with ESRD?
    - Chronic dialysis paid by state funds
- El Paso, Texas
  - What does the future hold for an uninsured, undocumented patient with ESRD?
    - Present to the emergency room when "sick"
    - Repatriation
    - Move to another state

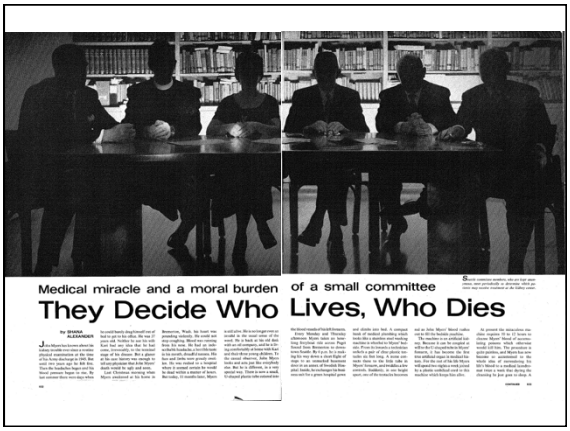
Definitions

- **Emergent Dialysis** Acute dialysis provided to patients only when there is a life-threatening need for this therapy.
- **Scheduled Dialysis** Maintenance dialysis provided on a regular scheduled basis.

When Access to Chronic Dialysis is Limited: One Center's Approach to Emergent Hemodialysis



Seminars in Dialysis
Volume 25, Issue 3, pages 267-271, 12 APR 2012 DOI: 10.1111/j.1525-139X.2012.01066.x
http://onlinelibrary.wiley.com/doi/10.1111/j.1525-139X.2012.01066.x/full#f1



Medical miracle and a moral burden of a small committee

They Decide Who Lives, Who Dies

The Current Political Environment and Hispanic Demographics

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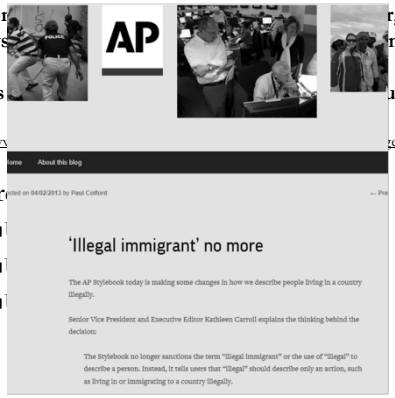


The Anti-Immigration Crusader
(John Tanton)
New York Times
By JASON DePARLE
Published: April 17, 2011

New York Times
http://www.nytimes.com/2011/04/17/us/17immig.html?pagewanted=1&_r=0&emc=eta1

Southern Poverty Law Center
http://www.splcenter.org/get-informed/intelligence-files/profiles/john-tanton

2011: Deferred Action for Child Arrivals (DACA)
Reprieve from the deportation of young undocumented immigrants in college or military.
2013: Border Security, Economic Opportunity, and Immigration Modernization Act
Creation of Registered Provisional Immigrant status.
Minimum of 13 years before citizenship.
Accelerated process for Child Arrivals (Dreamers).
2014: Executive Actions

Deferred Action for Childhood Arrivals (DACA) program

- 2017 689,800 DACA Recipients
- Health Care Options
  - Employer based benefit
  - College based benefit

AMERICAS

The New York Times

Mexico Moves to Encourage Caravan Migrants to Stay and Work

Migrants in Huixtla, Mexico, trying to take a lift in a sugar cane truck during their journey toward the United States. Alexandre Meneghini/Reuters

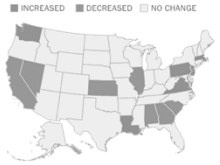
By Jeff Ernst and Kirk Semple

Jan. 25, 2019

Leer en español

Six states account for 59% of unauthorized immigrants: California, Texas, Florida, New York, New Jersey and Illinois

Estimated unauthorized immigrant populations grew in six U.S. states, declined in seven from 2009 to 2014



Note: Changes shown based on 90% confidence interval. Populations may have changed in additional states but these changes cannot be detected because they fall within the margin of error for these estimates.
Source: Pew Research Center estimates for 2009-2014 based on augmented American Community Survey (IPUMS).
"Overall Number of U.S. Unauthorized Immigrants Holds Steady Since 2009"

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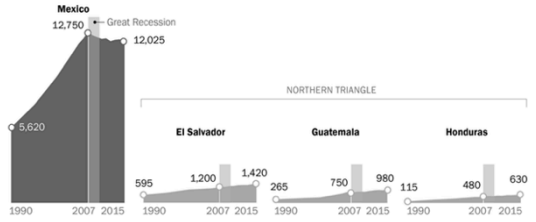
Since recession, U.S. immigrant populations from Northern Triangle rise as number from Mexico declines

In thousands



Note: All numbers rounded independently are not adjusted to sum to the U.S. total. See methodology for details. The Great Recession began in December 2007 and ended in June 2009, according to the National Bureau of Economic Research.
Source: Pew Research Center estimates based on adjusted 1990 census, augmented 1995 and 2000 Current Population Survey and augmented 2005-2015 American Community Survey (IPUMS).
"Rise in U.S. immigrants From El Salvador, Guatemala and Honduras Outpaces Growth From Elsewhere"

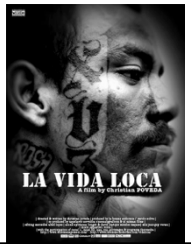
PEW RESEARCH CENTER

https://en.wikipedia.org/wiki/List_of_countries_by_intentional_homicide_rate

https://www.nybooks.com/articles/2011/11/10/new-gangland-el-salvador/

https://www.newyorker.com/news/news-desk/the-executioners-of-el-salvador

https://www.nybooks.com/daily/2017/01/27/el-salvador-a-town-without-violence/



https://www.youtube.com/watch?v=Q9dCWCvH1Zw

Terminology and Demographics of the US Latinx Population

U.S. Census Bureau 2010 Census Questionnaire

Figure 1.
Reproduction of the Question on Hispanic Origin From the 2010 Census

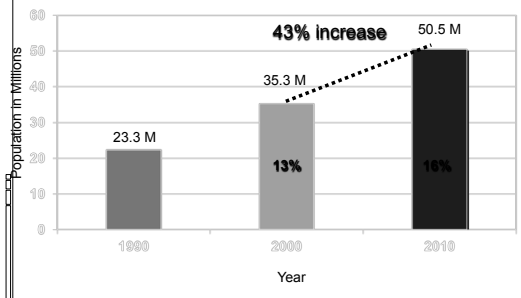
→ NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this census, Hispanic origins are not races.

5. Is this person of Hispanic, Latino, or Spanish origin?
   - ☐ No, not of Hispanic, Latino, or Spanish origin
   - ☐ Yes, Mexican, Mexican Am., Chicano
   - ☐ Yes, Puerto Rican
   - ☐ Yes, Cuban
   - ☐ Yes, another Hispanic, Latino, or Spanish origin — *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.*

Source: U.S. Census Bureau, 2010 Census questionnaire.

- Based on self-identification
- "Hispanic…origin"
  - Heritage
  - Nationality group
  - Lineage
  - Country of birth of the person or the person's parents or ancestors before their arrival in the U.S.
- May be any race

Latino Population Increase U.S. Census Bureau - 1990 to 2010



Demographics – U.S. 2015

- 56.6 million Hispanics living in U.S.
- 17.6% of total U.S. population
  - Central American 70.9%
  - Caribbean 15.5%
  - South American 5.5%

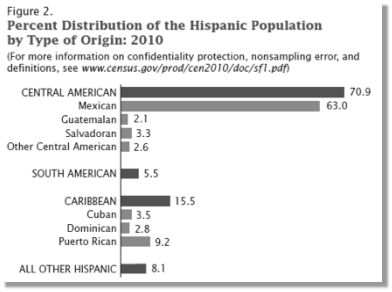
U.S. Census Bureau 2011

Pew Hispanic Center

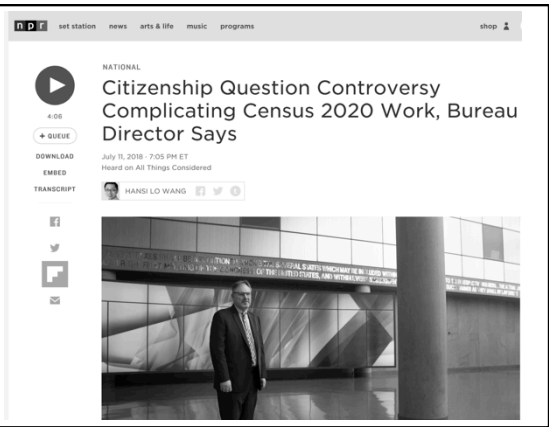
22

Hispanic Population - Distribution

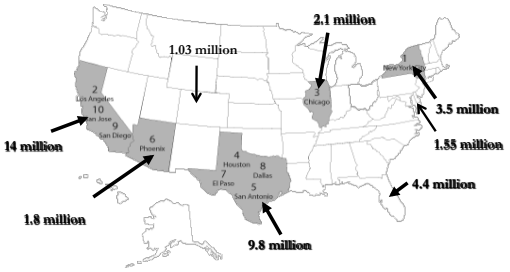
Figure 2.
Percent Distribution of the Hispanic Population by Type of Origin: 2010
(For more information on confidentiality protection, nonsampling error, and definitions, see *www.census.gov/prod/cen2010/doc/sf1.pdf*)



U.S. Census Bureau 2010

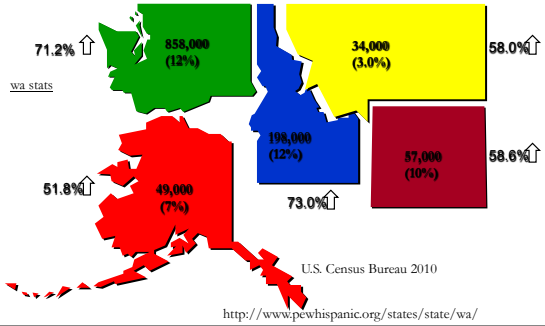


States in U.S. with Largest Hispanic Population – U.S. Census Bureau 2010



U.S. Census Bureau 2011

Total Hispanic Population in WWAMI - 2010

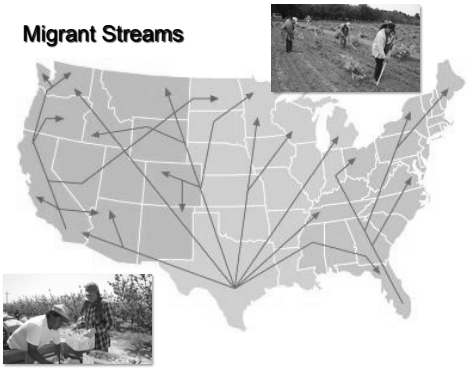


wa stats

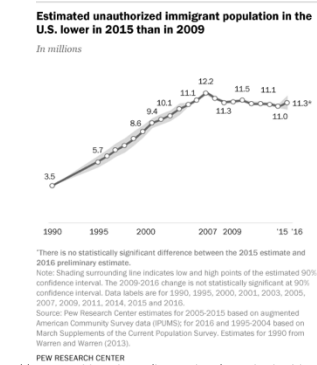
U.S. Census Bureau 2010

http://www.pewhispanic.org/states/state/wa/

Migrant Streams



Portrait of unauthorized Immigrants



http://www.pewhispanic.org/interactives/unauthorized-immigrants/

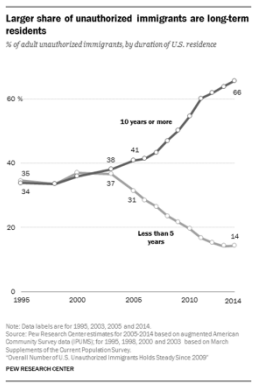


Table 2

Estimates of the U.S. Immigrant Population, Selected Years

	All immigrants	Legal	Legal temporary	Unauthorized
Population *(in thousands)*				
2012	41,700	28,300	1,700	11,700
2007	40,500	26,900	1,500	12,200
2005	38,100	25,600	1,450	11,100
2000	32,600	22,600	1,500	8,600
1995	26,900	20,000	1,100	5,700
Share				
2012	100	68	4	28
2007	100	66	4	30
2005	100	67	4	29
2000	100	69	5	26
1995	100	75	4	21

Notes: All populations rounded independently. Percentages compiled from unrounded numbers, so shares may not add to total.

Source: Pew Research Center estimates based on March Supplements to the Current Population Survey for 1995, 2007 and 2012 and the American Community Survey for 2005. All estimates adjusted for omissions. See Methodology.

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Mexico and Central American nations are among top birth countries of unauthorized immigrants

In thousands

	2014	2009	Change*
Mexico	5,850	6,350	-500
El Salvador	700	650	n.s.
Guatemala	525	475	+50
India	500	350	+130
Honduras	350	325	+50
China	325	300	n.s.
Philippines	180	180	n.s.
Dominican Rep.	170	150	n.s.
Korea	160	180	n.s.
Ecuador	130	140	n.s.
Colombia	130	150	n.s.
Peru	100	120	n.s.
Haiti	100	85	n.s.
Brazil	100	140	-40
Canada	100	95	n.s.
U.S. total	**11,100**	**11,300**	**n.s.**

*Each number in this chart is rounded based on a set of rules specified in Methodology. Subtracting the 2009 population total from the 2014 population total for any country may produce a different result than shown in the change column because of this rounding. The number in the change column is the more precise estimate of difference.
Note: China includes Hong Kong and Taiwan. Significant changes are based on 90% confidence interval. The symbol "n.s." means the change is not statistically different from zero.
Source: Pew Research Center estimates for 2009-2014 based on augmented American Community Survey (IPUMS).
"Overall Number of U.S. Unauthorized Immigrants Holds Steady Since 2009"

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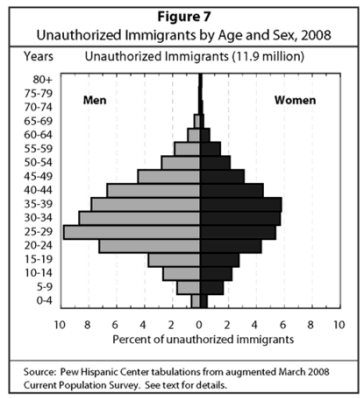

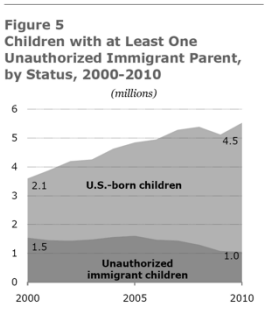

Note: Children are persons under age 18 who are not married.

Source: Pew Hispanic Center estimates based on augmented March Supplements to the Current Population Survey. See Methodology.

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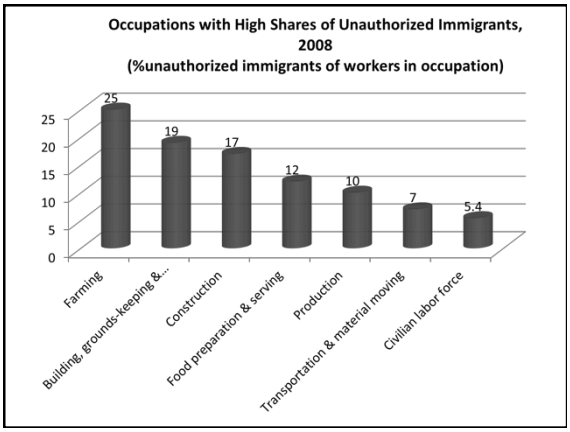


Income and Education

- Median Household Income: 35-38 K (US 50 k)
- Adults below poverty level: 21% (10%)
- Share of Children below poverty level: 33% (18%)
- Low Educational Attainment: 29% less than 9th grade (2%)

Financial Cost of Immigrants

- Social Security Suspense File
  - 1.2 trillion dollars
- "Overall, immigrants almost certainly paid more toward medical expenses than they withdrew, providing a low-risk pool that subsidized the public and private health insurance markets. We conclude that insurance and medical care should be made more available to immigrants rather than less so."

Groups examined	Key findings
Immigrants	Lower medical expenditures by immigrants than U.S.-born citizens,[6,13,17–20] even when insured.[17]
	Immigrants with nonfatal occupational injuries have similar medical expenditures to U.S.-born citizens.[18]
	Latino immigrants have lower expenditures than U.S.-born Latinos and U.S.-born white citizens.[16]
Recent arrivals (fewer than 10 years residence)	Recent arrivals have fewer expenditures than more established immigrants and U.S.-born citizens.[16,17]
	During the Great Recession of 2007–2009, undocumented immigrants in the U.S. less than 5 years were less likely to report any health care–related spending and those who did spent more.[21]
Established immigrants (greater than 10 years residence)	Established immigrants have lower expenditures than U.S.-born citizens, particularly if they were undocumented.[16,17]
	Medical expenditures for established immigrants were roughly two-thirds that of U.S.-born citizens.
Undocumented immigrants	Undocumented immigrants had lower expenditures compared to naturalized immigrants and U.S.-born citizens[5,13,16,19,20] and overall contributed a greater amount to Medicare's Trust Fund than they withdrew.[18]
	Undocumented immigrants in the U.S. longer than 5 years had similar health care spending to citizens during the Great Recession 2007–2009.[21]
Naturalized immigrants	Lower expenditures for naturalized immigrants compared to U.S.-born citizens.[5,18]
Immigrant children	Lower expenditures among immigrant children, except emergency department expenditures, which are higher among immigrant children compared to nonimmigrants.[13]
Older adult immigrants (greater than age 65)	Lower overall expenditures, but more likely to spend higher proportion of income on OOP expenditures compared to U.S.-born older adults.[14]
	After age 65, differences in spending between foreign-born and native adults disappear due to near universal Medicare coverage.[14]

Table 2. Expenditures by Immigrant Groups.

Published in: Lila Flavin; Leah Zallman; Danny McCormick; J. Wesley Boyd; *Int J Health Serv* 48, 601-621.
DOI: 10.1177/0020731418791983

Questions/Discussion

Estimate of Undocumented Immigrants with ESRD

Prevalence estimates: State Funded Chronic Dialysis

- California:
  - 1350 ESRD patients
  - crude estimate of 529 PPM (70% Mexican)
- Illinois:
  - 686 ESRD patients
  - crude estimate of 1321 PPM (72% Mexican)
- Arizona
  - 250 ESRD Patients
  - Crude estimate of 1024 PPM (86% Mexican)

Prevalence estimates: Emergent Dialysis-single center reports

- Huston, Texas:
  - 350 patients
  - Crude estimate of 930 PPM (63% Mexican)
- Texas
  - Estimated to have 1000 patients
  - Crude estimate of 680 PPM (78% Mexican)

Personal Communication: Rajeev Raghavan, MD, FASN and Tex Med. 2014;110(7):e1. By Rohit Kuruvilla and Rajeev Raghavan, MD

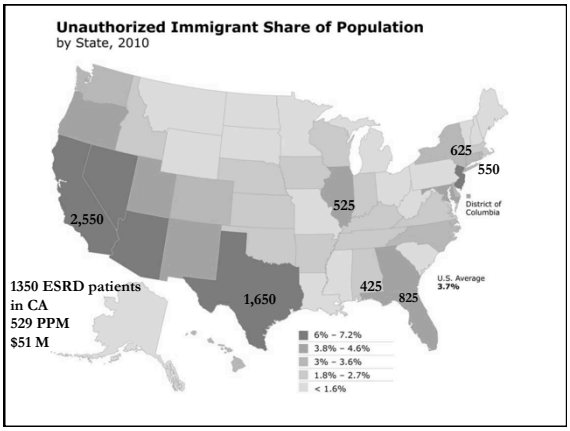
Prevalence estimates: Emergent Dialysis-single center reports

- Denver, Colorado
  - 65 patients
  - Crude estimate of 1365 PPM (88% Mexican)
- Las Vegas, Nevada
  - 70 patients
  - Crude estimate of 660 PPM (74% Mexican)

Personal Communication: Lilia Cervantes, M.D.

Prevalence Estimates

- Undocumented Immigrant Population in the US: 11 Million
- Using the lowest prevalence of 529 PPM
  - 5819 Undocumented Immigrants with ESRD



Questions/Discussion

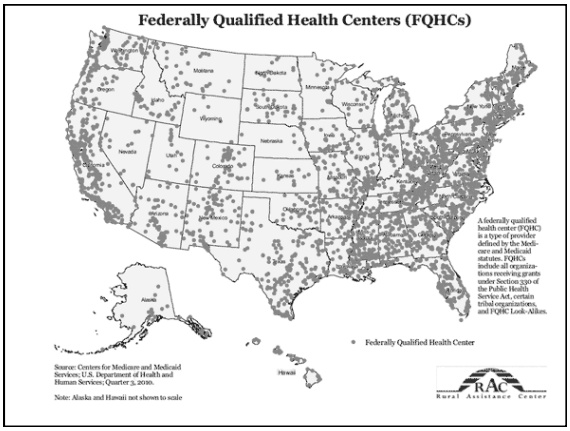
Health Care Options

Migrant Worker History

- 1942 Bracero Agreement
- 1950 Bracero Agreement Extended, H-2 Program
- 1962 Migrant Health Act of 1962
- 1964 Bracero Program Ends
- 1980 Migrant and Seasonal Agricultural Protection Act
- 1986 H2-A Program Starts

Community and Migrant Health Centers

- Migrant Health Act, September 25, 1962
  - Signed into law by President John F. Kennedy
  - established the authorization for delivery of primary and supplemental health services to migrant farmworkers.



- California Agricultural Workers Health Survey
  - 38% of undocumented men never had visited a doctor or clinic
  - elevated prevalence of indicators of chronic disease in the US.

The Health of California's Immigrant Hired Farmworkers
AMERICAN JOURNAL OF INDUSTRIAL MEDICINE 53:387–397 (2010)

- *New York Experience with Pre-ESRD Care*
  - *27% of undocumented immigrant dialysis patients had pre-ESRD care (vs. 61%)*

The Initiation of Dialysis in Undocumented Aliens: The Impact on a Public Hospital System. Am J Kidney Dis 43:424-432.

Pre-Dialysis issues

- Poor access to nephrology subspecialty care
- Pre-Dialysis Planning
  - No access to transplantation
  - Barriers to proper Dialysis planning (fistula)

Dialysis: Why the regional differences in dialysis care?

- What legal and regulatory issues have resulted in the regional differences?
  - "Compassionate Dialysis" vs. Standard Renal Care in other states

Trends in Emergency Medicaid Expenditures for Recent and Undocumented Immigrants JAMA. 2007;297:1085-1092

- Characteristics of North Carolina Emergency Medicaid Patient Population (2001-2004)
  - Pregnant women 43,339 (89.6%)
  - Aid to families 2902 (6.0%)
  - Infants and children 1169 (2.4%)
  - Disabled 604 (1.3%)
  - Elderly 377 (0.8%)
- 93% Hispanic, 90% <40 years old, 99.2% undocumented
- **$ 52.9 Million in 2004, chronic renal failure (8%),**

Medicaid Coverage of Emergency Medical Conditions

- 1965: Medicaid Act enacted
  - did not address the availability of Medicaid to noncitizens
  - U.S. Department of Health, Education and Welfare (the DHHS predecessor) interpreted the statute to allow coverage.
- 1973: Congress amended Social Security Act
  - denied any Medicaid eligibility to any noncitizen who was not a permanent resident or otherwise permanently residing in the United States under color of law.
- 1986: a federal district court in New York held that the regulation violated the Medicaid statute.

- 1986: Congress amends the Medicaid Act
  (Emergency Medical Treatment & Labor Act (EMTALA)
  - exclude certain "aliens" from receiving full-scope Medicaid assistance.
  - Medicaid payments "shall be made" if
    - such care and services are necessary for the treatment of an emergency medical condition of the alien
    - such alien otherwise meets the eligibility requirements for medical assistance under the state plan … and
    - such care and services are not related to an organ transplant procedure.

- Medicaid Act defines the term "emergency medical condition" to mean a medical condition (including emergency labor and delivery) 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
  - placing the patient's health in serious jeopardy,
  - serious impairment to bodily functions, or
  - serious dysfunction of any bodily organ or part.
  - services are limited to those required "after the sudden onset" of a medical condition.

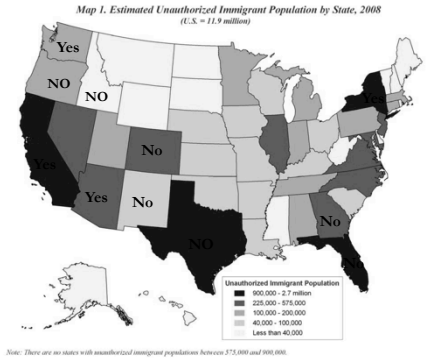
Legal Challenges

- Gaddam v. Rowe, Conn. Super. Ct. 1995
  - refused to allow the medical Russian roulette that the state agency position requires; i.e., stop the [dialysis] payment, wait a short time for symptoms to recur and then hope there is time to get the patient to the hospital to restart the treatment before the patient dies.
- Greenery Rehabilitation Group v. Hammon, 1998
  - Second Circuit held that coverage of emergency medical conditions for sudden traumatic brain injuries ended after the initial injury was stabilized and did not include the continuous and regimented treatment of the patients subsequent symptoms.
- Connecticut state courts have been particularly influenced by Greenery, Quiceno, 728 A.2d at 553. 1999.
  - "fatal consequences of the discontinuance of ... ongoing [dialysis] care does not transform into emergency medical care"

Legal Challenges

- Arizona Health Care Cost Containment System (AHCCCS)/Medicaid
  - changed its definition of emergency services (dialysis not included) in 2000 to match strict federal guidelines outlined by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act).
  - William E. Morris Institute for Justice and the Arizona Center for Disability Law, representing a group of immigrants, sued the state in 2002 in federal court
    – Cover dialysis (AHCCCS=Arizona's Medicaid program)
    – No witness for AHCCCS

DIALYSIS OF UNDOCUMENTED IMMIGRANTS



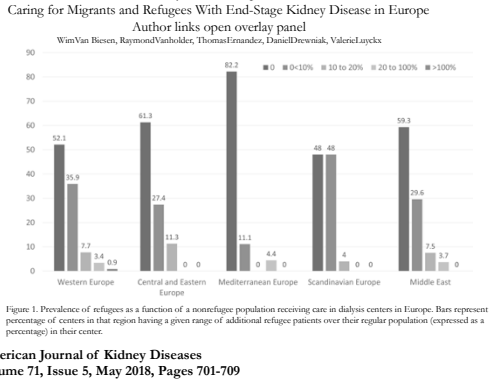


Figure 1. Prevalence of refugees as a function of a nonrefugee population receiving care in dialysis centers in Europe. Bars represent percentage of centers in that region having a given range of additional refugee patients over their regular population (expressed as a percentage) in their center.

American Journal of Kidney Diseases
Volume 71, Issue 5, May 2018, Pages 701-709

Policy Forum Perspective
Caring for Migrants and Refugees With End-Stage Kidney Disease in Europe
Author links open overlay panel
WimVan Biesen, RaymondVanholder, ThomasFernandez, DanielDrewniak, ValerieLuyckx

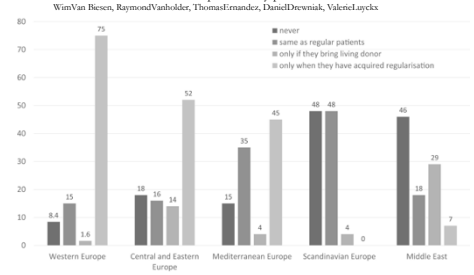


Figure 3. Approaches to transplantation of refugees in different regions of Europe and Middle East.

American Journal of Kidney Diseases
Volume 71, Issue 5, May 2018, Pages 701-709

Policy Forum Perspective
Caring for Migrants and Refugees With End-Stage Kidney Disease in Europe
Author links open overlay panel
WimVan Biesen, RaymondVanholder, ThomasFernandez, DanielDrewniak, ValerieLuyckx

Figure 2. Responsibilities relating to end-stage kidney disease care for refugees and migrants at different societal levels of decision making and organization.

American Journal of Kidney Diseases
Volume 71, Issue 5, May 2018, Pages 701-709

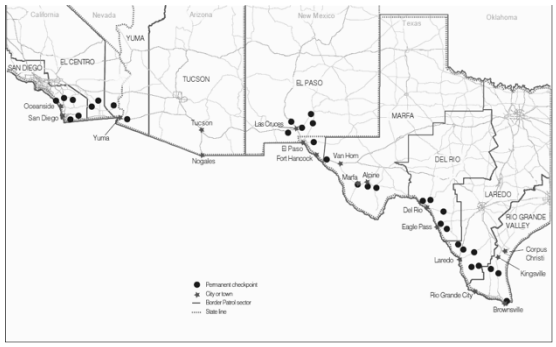
Questions/Discussion

Choices for Patients with ESRD

- California, Washington, and New York
  - Medicaid/State Fund coverage for chronic dialysis
  - No transplantation
- Texas
  - "compassionate dialysis" or dialysis in emergent situation
- Safety Net Hospital Model
  - Grady Hospital (Atlanta) and Jackson Memorial (Florida)*
- Medical Repatriation
- Moving to another State

***Personal Communication: Gabriel N. Contreras, M.D., University of Miami**

Moving to another State



- Uninsured
December

was
He
who

simply
care Unit."

edical-leave

Situation in Mexico

- Returning Grady Patients (2012)[1]
  - 6/11 Dead, 4/11 unknown, 1 alive
- Prevalence Rate dialysis and transplant[2]
  - Dialysis
    - Insured 1211 per Million (2010)
    - Uninsured 231 per Million (2010)
  - Transplant
    - Insured 122 PPM (2010)
    - Uninsured 12 PPM (2010)

1. Personal Communication: Dr. Guillermo García García, FACP, FASN
2.Garcia G et al; Semin Nephrol 2010;30:3-7
Garcia G et al; Kidney Int 2005;Suppl 97: 58-61

Renal replacement therapy among disadvantaged populations in Mexico: a report from the Jalisco Dialysis and Transplant Registry (REDTJAL).
Kidney International, Vol. 68, Supplement 97 (2005), pp. S58–S61

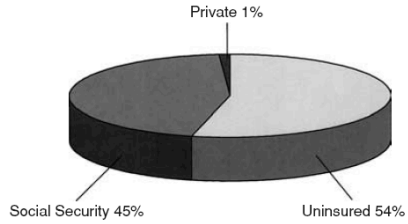
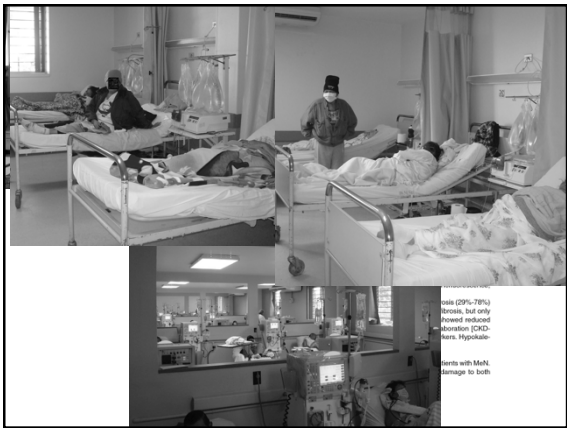


Fig. 1. Health Care in Jalisco. Distribution by type of medical insurance.

Hospital Falters as Refuge for Illegal Immigrants
New York Times, Kevin Sack
November 20, 2009

"To have end-stage renal disease in Mexico is a tragedy," said Dr. Guillermo Garcia-Garcia, the lead author of the study. "If you don't have Social Security, if you don't have private insurance, you are condemned to die."



Safety Net Hospital in El Salvador

Modality	Location	Machines /Beds	patients #	Frequency	Access
Outpatient Hemodialysis	Dialysis Unit	30 machines	250	2 x week dialysis	Fistula
Outpatient PD	Home	CAPD	135	Daily	PD Catheter
PD Cycler	Dialysis Unit	30 Cyclers	180	Once a week	PD Catheter
PD Manual	Dialysis Unit	36 Beds for Manual exchanges	252	Once a week	PD Catheter
Hospitalized Patients with new ESRD	Hospital	Intermittent PD	250 (40-50 new patients per month)	Acute, Once a week	Rigid PD Catheter

Personal Communication: Dr. Ricardo Alberto Leiva Merino
Chief of Nephrology Service, Hospital Nacional Rosales

Call to Action and Reviewing the evidence

In a 2009 editorial, the Chief Medical Officer for the Centers for Medicare and Medicaid Services (CMS), Barry Straube, challenged the nephrology community to obtain more data and information to best define options and reform national and state policies, and stressed the need to obtain more evidence-based and cost-effectiveness analyses on the best way to treat this undocumented immigrants with ESRD.

Straube BM. Reform of the US healthcare system: care of undocumented individuals with ESRD.
the National Kidney Foundation. Jun 2009;53(6):921-924.

The JAMA Network

From: **Association of Emergency-Only vs Standard Hemodialysis With Mortality and Health Care Use Among Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2018;178(2):188-195. doi:10.1001/jamainternmed.2017.7039

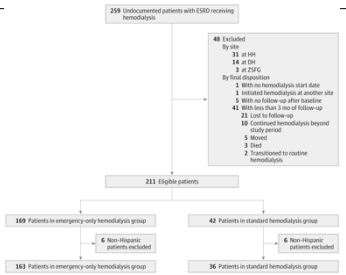


Figure Legend:

Patient Flow DiagramDH indicates Denver Health; ESRD, end-stage renal disease; HH, Harris Health; and ZSFG, Zuckerberg San Francisco General Hospital.

The JAMA Network

From: **Association of Emergency-Only vs Standard Hemodialysis With Mortality and Health Care Use Among Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2018;178(2):188-195. doi:10.1001/jamainternmed.2017.7039

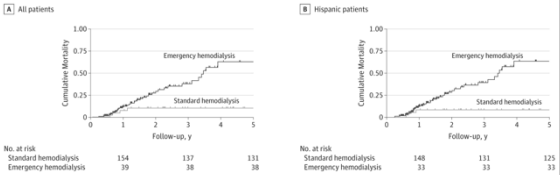


Figure Legend:

Cumulative Mortality for Patients Treated With Emergency Hemodialysis vs Standard Hemodialysis

The JAMA Network

From: **Association of Emergency-Only vs Standard Hemodialysis With Mortality and Health Care Use Among Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2018;178(2):188-195. doi:10.1001/jamainternmed.2017.7039

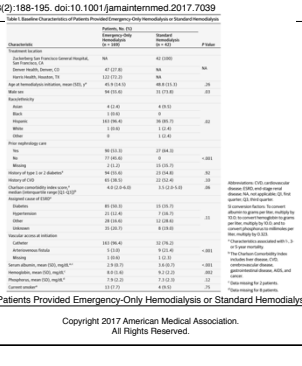


Table Title:

Baseline Characteristics of Patients Provided Emergency-Only Hemodialysis or Standard Hemodialysis

Association of Citizenship Status With Kidney Transplantation in Medicaid Patients

Jenny I. Shen, Daniel Hercz, Lilly M. Barba, Holly Wilhalme, Erik L. Lum, Edmund Huang, Uttam Reddy, Leslie Salas, Sitaram Vangala, and Keith C. Norris

Am J Kidney Dis. 71(2): 182-190. Published online November 8, 2017.

AJKD

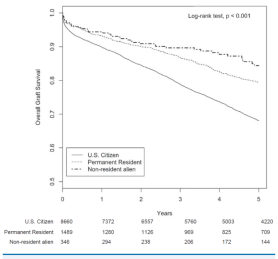


Figure 2. Kaplan-Meier curve for unadjusted overall transplant survival in adult Medicaid patients who received kidney transplants from 1990 through 2011, by citizenship status

From: **Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2019;179(2):175-183. doi:10.1001/jamainternmed.2018.5866

JAMA Network

Table 1. Baseline Characteristics of the Study Population

Characteristic	Emergency-Only Dialysis (n = 76)	Scheduled Dialysis (n = 105)
Age, mean (SD), y	51.9 (15.7)	45.3 (12.0)
Female sex, %	50.0	40.0
Race or ethnic group, %		
White	0.0	1.0
Black	2.6	0.0
Hispanic	97.4	97.1
Months in health system prior to baseline period, median (IQR)	73 (19-172)	78 (29-160)
Dialysis characteristics		
Dialysis vintage, median (IQR), mo[a]	17 (6-29)	24 (11-38)
Frequency of dialysis per wk, median (IQR)	1.1 (0.8-1.5)	1.6 (1.1-2.0)
Vascular access type prior to enrollment, %		
Central venous catheter	85.5	82.9
Arteriovenous fistula or graft[b]	14.5	17.1
Charlson comorbidity index, median (IQR)	4 (3-4)	4 (3-4)
Key comorbidities, %		
Diabetes	69.7	69.5
Hypertension	92.1	92.4
Autoimmune illness	31.6	30.5
ESRD and emergency dialysis–related hospitalizations, %		
Central catheter–associated bloodstream infection	31.6	24.8
Endocarditis	11.8	10.5
Sepsis	18.4	21.9
Ascites requiring paracentesis	10.5	11.4
Laboratory measurements, median (IQR)		
Potassium, mEq/L	5.4 (4.8-6.1)	5.7 (5.0-6.2)
Bicarbonate, mEq/L	21 (18-25)	21 (19-24)
Blood urea nitrogen, mg/dL	91 (71-106)	84 (67-100)
Creatinine, mg/dL	10.6 (7.5-13.1)	11.9 (9.8-14.9)
eGFR, mL/min/1.73 m^2[c]	6 (4-9)	4 (3-6)
Calcium, mg/dL	8.5 (7.7-9.2)	8.6 (8.1-9.2)
Phosphorus, mg/dL	6.5 (5.1-7.8)	6.7 (5.5-8.2)
Hemoglobin, g/dL	9.5 (8.8-10.1)	9.3 (8.7-10.0)
Albumin, g/dL	3.5 (3.2-3.8)	3.8 (3.5-4.0)

Table Title:

Baseline Characteristics of the Study Population

JAMA Network

From: **Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2019;179(2):175-183. doi:10.1001/jamainternmed.2018.5866

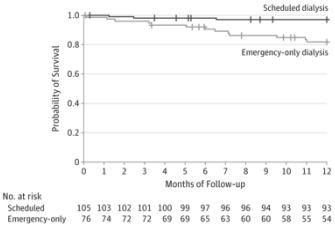


Figure Legend:

Survival Rates in Scheduled vs Emergency-Only DialysisFigure shows the Kaplan-Meier estimates of overall survival during the 12-month follow-up period. Individuals were censored at death (n = 16) or loss to follow-up (n = 20). The overall unadjusted mortality rate was 3% in the scheduled dialysis group (n = 3) compared with 17% in the emergency-only dialysis group (n = 13; P = .001), corresponding to an estimated absolute risk reduction of 14% and number needed to treat of 7 at 12 months. The adjusted hazard ratio for death for emergency-only vs scheduled dialysis was 4.6 (95% CI, 1.2-18.2; P = .03) by log-rank test.

JAMA Network

From: **Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2019;179(2):175-183. doi:10.1001/jamainternmed.2018.5866

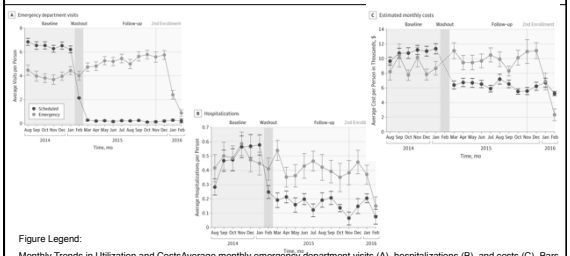


Figure Legend:

Monthly Trends in Utilization and CostsAverage monthly emergency department visits (A), hospitalizations (B), and costs (C). Bars indicate standard error. Enrollment was in February 2015 (washout). Grey dotted line marks the start of the second open enrollment (November 2015-February 2016), when 92% of those remaining on emergency-only dialysis enrolled.

From: **Association of Scheduled vs Emergency-Only Dialysis With Health Outcomes and Costs in Undocumented Immigrants With End-stage Renal Disease**

JAMA Intern Med. 2019;179(2):175-183. doi:10.1001/jamainternmed.2018.5866

JAMA Network

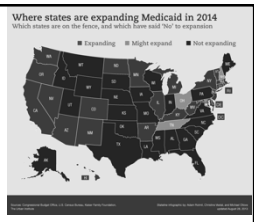
Table 2. Influence of Scheduled Dialysis on Health Care Utilization and Costs[a]

	Emergency-Only Dialysis (n = 76)			Scheduled Dialysis (n = 105)				
Outcome	Baseline	Follow-up	Net Change[b]	Baseline	Follow-up	Net Change[b]	Difference-in-Differences (95% CI)[c]	P Value
Unadjusted Average Utilization Rates								
ED visits per mo	4.0	4.5	+0.6	6.3	0.2	−6.1	−6.7 (−7.3 to −6.0)	<.001
Dialysis ED visits per mo	3.5	4.3	+0.8	5.6	0.0	−5.5	−6.3 (−7.0 to −5.7)	<.001
Non-dialysis ED visits per mo	0.5	0.3	−0.2	0.8	0.2	−0.6	−0.4 (−0.6 to −0.2)	<.001
Hospitalizations per 6 mo	3.0	2.4	−0.5	3.0	1.0	−2.0	−1.5 (−2.3 to −0.8)	<.001
Hospital d per 6 mo	22.4	24.1	+1.7	14.8	6.4	−8.4	−10.1 (−17.7 to −2.5)	.009
Adjusted Average Utilization Rates[d]								
ED visits per mo	5.0	6.1	+1.1	5.3	0.2	−5.2	−6.2 (−7.0 to −5.4)	<.001
Dialysis ED visits per mo	4.4	5.6	+1.2	4.8	0.0	−4.7	−6.0 (−6.7 to −5.2)	<.001
Non-dialysis ED visits per mo	0.6	0.4	−0.2	0.6	0.1	−0.5	−0.2 (−0.4 to −0.04)	.02
Hospitalizations per 6 mo	2.9	2.3	−0.5	3.1	1.0	−2.1	−1.6 (−2.3 to −0.8)	<.001
Hospital d per 6 mo	19.2[e]	20.0	+0.8	16.7[e]	7.6	−9.2	−9.9 (−17.1 to −2.7)	.007
Costs: Best-Case Scenario[f]								
Unadjusted costs PPPM, $	8317	9581	+1264	11 223	6288	−4935	−6199 (−8677 to −3721)	<.001
Adjusted costs PPPM, $[g]	8691	10 146	+1455	10 802	6090	−4711	−6166 (−8753 to −3579)	<.001
Costs: Worst-Case Scenario[h]								
Unadjusted costs PPPM, $	8317	9581	+1264	11 223	6697	−4525	−5790 (−8246 to −3333)	<.001
Adjusted costs PPPM, $[g]	8686	10 138	+1452	10 806	6490	−4316	−5768 (−8332 to −3204)	<.001

Table Title:

Influence of Scheduled Dialysis on Health Care Utilization and Costs[a]

Questions/Discussion



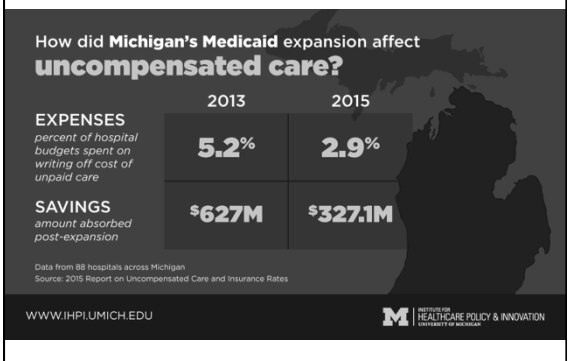
Los Angeles Times

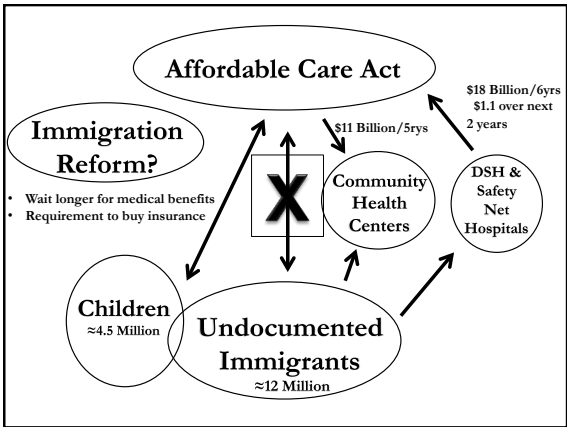
Wednesday, October 29, 2008

Dialysis dilemma: Who gets free care?

"the Georgia Medicaid program stopped paying for dialysis in 2006 amid rising sentiments in the Legislature that illegal immigrants were a financial drain.

"Georgia ain't California or New York," said Mark Trail, head of Georgia's Medicaid program until last month, noting a strong conservative tradition.





The NEW ENGLAND JOURNAL of MEDICINE

Perspective

MAY 3, 2018

Care for Undocumented Immigrants — Rethinking State Flexibility in Medicaid Waivers

A. Taylor Kelley, M.D., M.P.H., and Renuka Tipirneni, M.D.

Ever since President Donald Trump took office, the Department of Health and Human Services (HHS) has promised that states would enjoy more flexibility in structuring their Medicaid pro- and employer-provided benefits, including health insurance. Many will leave the country, but many others will probably stay to avoid life-threatening violence and dismal economic prospects in their

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

NOVEMBER 17, 2016

Covering Undocumented Immigrants — State Innovation in California

Rachel Fabi, B.A., and Brendan Saloner, Ph.D.

The proportion of undocumented immigrants in the United States who lack health insurance continues to be high — around 40%[1] — even as the country's overall uninsured rate has dropped to historic lows under the Affordable Care Act (ACA). Insuring undocumented immigrants would be an important step toward achieving universal coverage, but in an immigrants. California, home to about 2.5 million undocumented residents, introduced three relevant measures in the 2015–2016 legislative session. The first policy, passed vides undocumented-immigrant children with access to coverage through Medi-Cal, the state Medicaid program. Its passage makes California the largest state to use state-only funding to provide coverage to all children regardless of immigration status; in doing so, it joins New York, Illinois, Massachusetts, Washington, and the District of Columbia. There has been

Medical Professionalism in the New Millennium: A Physician Charter

Ann Intern Med. 2002 Feb 5;136(3):243-6.

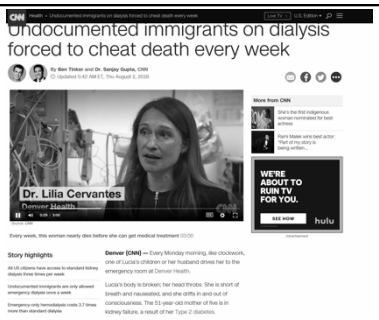
- **Fundamental Principles**
  - *Principle of primacy of patient welfare.*
    - This principle is based on a dedication to serving the interest of the patient.
  - *Principle of patient autonomy.*
  - *Principle of social justice.*
    - The medical profession must promote justice in the health care system, including the fair distribution of health care resources. Physicians should work actively to eliminate discrimination in health care, whether based on race, gender, socioeconomic status, ethnicity, religion, or any other social category.

Renal Physicians Association position statement

Clin Nephrol. 2000 Sep;54(3):253-4

- The federal government has an ethical and fiscal responsibility to provide care for patients within our borders.
- The financial burden of this care should fall not only on those states who have the highest number of non-citizens, but it should be distributed evenly among all fifty states.
- Without imposing an unreasonable burden on themselves or others all health-care professionals and health-care systems have an ethical obligation to treat the sick.
- All non-citizens should be eligible for emergency Medicaid services if they do not have insurance or resources to pay for dialysis.
- Nephrologists should not be expected to act as agents for the immigration and Naturalization Service and should not be expected to report undocumented non-citizens because of confidentiality and the fiduciary nature of the patient-physician relationship.
- The ESRD Networks should be involved in coordinating the sharing of care of uninsured non-citizens in their region.

Success Stories



- https://www.cnn.com/2018/08/02/health/kidney-dialysis-undocumented-immigrants/index.html

New Opportunities for Funding Dialysis-Dependent Undocumented Individuals
Rajeev Raghavan
CJASN February 2017, 12 (2) 370-375

- Medical Center or other entity is able to purchase insurance for undocumented immigrants with the assistance of non-profit organization.

The power of medical directors

- Some medical directors report negotiating with dialysis centers for “charity care”

Summary

- Patient Portrait
  - Young, working poor population
  - Few viable choices for patients in states not offering chronic dialysis
  - Urgent need for federal plan
  - Advocacy can make a difference
- Prevention and Early Detection
  - Federally Qualified Health Centers
  - Safety Net Hospitals

Summary

- Palliative Care
- Transplantation
- Immigration Reform
  - Future Solution to our current ethical dilemma
  - Need for loud voices from local communities to the national level
    - Professional Societies
    - Nephrology Community