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Dialysis Care for Undocumented Immigrants With Kidney Failure in the COVID-19 Era: Public Health Implications and Policy Recommendations

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As cases of coronavirus disease 2019 (COVID-19) infection increase, we must pause to consider a particularly vulnerable community: undocumented immigrants with kidney failure. According to estimates from 2019, there are between 5,500 and 8,857 undocumented immigrants with kidney failure in the United States.[1] This group tends to be Latino and when compared with the US documented Latino community with kidney failure, they are younger, have fewer comorbid conditions, have a lower educational level, and are less likely to receive pre–kidney failure care.[2,3] In many states, these patients do not have funding for standard outpatient dialysis care.[4,5] They rely on emergency-only dialysis (dialysis only after presenting critically ill to an emergency department), which happens on average 6 times per month.[3] This population is potentially at increased risk for complications and death if infected with COVID-19, but they risk potential exposure for themselves and their families every time they present for dialysis and occupy much needed emergency and inpatient resources.

We describe the public health implications of emergency-only dialysis in the COVID-19 era and make policy recommendations that will protect undocumented immigrants with kidney failure, increase inpatient and dialysis resources, and help stop the spread of COVID-19 in our communities.

Emergency-Only Dialysis and Public Health Implications in the COVID-19 Era

Standard of care for people with kidney failure is thrice-weekly outpatient hemodialysis, daily peritoneal or home hemodialysis, or kidney transplantation. Undocumented immigrants are excluded from the provisions of the Affordable Care Act, the diagnosis-based 1972 Medicare End-Stage Renal Disease entitlement program, and a range of federally funded Medicaid programs that pay for standard outpatient dialysis. The Emergency Medical Treatment and Active Labor Act requires hospitals to treat anyone who enters with an emergency medical condition, enabling undocumented immigrants to receive dialysis when they present to hospitals with emergency indications.[4]

Emergency-only dialysis is associated with lower quality of life, high symptom burden, and significant anxiety about death.[3] Compared with people receiving standard dialysis, this population's 5-year mortality is 14-fold higher and they spend more time in the hospital and less time in the outpatient setting.[3] Emergency-only dialysis is taxing on the health care system. Studies show that their providers experience emotional exhaustion and burnout from the perception of propagating unjust, unethical, and substandard medical care.[4] It is also extremely costly: emergency-only dialysis costs $285,000 to $400,000 per person per year,[6] compared with $76,177 to $90,971 per person per year for standard dialysis.[7] Switching from emergency-only dialysis to outpatient dialysis is associated with a cost reduction of $5,768 per person per month.[8]

Each presentation for emergency-only hemodialysis risks exposure to COVID-19. The Latino community is already at disproportionately higher risk for COVID-19 infection and death, attributed to the inability to socially distance in work and living environments, higher rates of comorbid conditions, and poor access to care.[9,10] As such, a COVID-19 infection acquired through emergency-only hemodialysis could result in an exponential increase in the number of COVID-19 infection cases in the community.

Recent policy initiatives that expand access to COVID-19 treatment, such as the Families First Coronavirus Response Act; the Coronavirus Aid, Relief, and Economic Security Act; and the proposed Take Responsibility for Workers and Families Act, do not alter Medicaid eligibility, thereby excluding undocumented immigrants.[11,12] As a result, these patients and their family members do not have access to primary care or mobile testing sites, instead relying on emergency

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Policy Forum highlights aspects of nephrology relating to payment and social policy, legislation, regulation, demographics, politics, and ethics, contextualizing these issues as they relate to the lives and practices of members of the kidney community, including providers, payers, and patients.

departments. If admitted, undocumented immigrants are eligible for coverage through Emergency Medicaid, though hospital discharge may be delayed because Emergency Medicaid does not cover services following hospital discharge, such as oxygen therapy, telehealth, primary care, or rehabilitation.[13]

The symptoms that emergency-only dialysis patients experience when they need treatment may be confused for symptoms of COVID-19 infection. Severe shortness of breath from volume overload, malaise, and nausea may prompt emergency department clinicians to unnecessarily test for COVID-19 when tests are still limited. Each admission for dialysis unnecessarily uses inpatient beds, dialysis supplies, and nursing resources that could be otherwise used for patients with COVID-19 infection. This is especially problematic in communities facing a surge in COVID-19 infection cases, when nephrologists may need to consider altering dialysis treatments to meet the needs of greater numbers of patients.[14]

Undocumented immigrants who rely on emergency-only dialysis may also be avoiding the hospital and extending the time between their dialysis admissions to avoid COVID-19 exposure. They are also likely avoiding care due to the US Citizenship and Immigration Services (USCIS) new Inadmissibility on Public Charge Grounds rule, which negatively weighs the use of public assistance, such as nutrition assistance, nonemergency Medicaid, and housing benefits, against any applicant for permanent residence and their dependents.[15] Though the USCIS announced suspension of the public charge rule related to COVID-19 care, widespread fear among immigrant communities will likely lead to fewer seeking care. Increasing time between dialysis sessions increases the risk for fatal arrythmias, hypoxia from volume overload, uremia, and complications when they finally receive dialysis. Whether this will result in an even higher relative risk for death for these patients compared with the general population with kidney failure remains to be seen.

Alternatives to Emergency-Only Dialysis

In 12 states, undocumented immigrants are able to receive outpatient dialysis. This was accomplished by changing the scope of each state's Emergency Medicaid coverage to include outpatient dialysis. Federal law defines an emergency medical condition as "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 – (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 (Social Security Act § 1903(v)(3))." There is no stipulation that emergency medical conditions have to be treated in the inpatient setting, and the Centers for Medicare & Medicaid Services defer to states to determine what conditions qualify as emergencies.

As an example, Arizona's Medicaid Policy Manual clearly defines outpatient dialysis as services that are covered by Emergency Medicaid. Undocumented immigrants may receive scheduled outpatient dialysis if the treating provider signs a monthly certification stating that the absence of thrice-weekly dialysis would place the individual's health in serious jeopardy. Inclusion of outpatient dialysis in the state's definition of an emergency medical condition allows the same funds to cover outpatient dialysis instead of inpatient admissions for emergency-only dialysis.[4]

In states in which Emergency Medicaid does not cover outpatient dialysis, outpatient dialysis may be procured by acquiring private insurance (sometimes paid for by nonprofit entities that provide charitable support) or through county-funded and safety net hospital-funded outpatient dialysis centers.[4] However, due to restrictions on these programs and limitations of charitable support, there are always individuals who rely on hospitals for emergency-only dialysis. The end result is a patchy system across the country, with highly variable care between states and a vulnerable population that unnecessarily exposes themselves to COVID-19 and occupies much needed inpatient resources.

Policy Recommendations

Bold action is required to protect immigrant populations during the COVID-19 pandemic and should include a move toward covering outpatient dialysis in all 50 states. Although attending thrice-weekly outpatient dialysis also introduces the chance of COVID-19 exposure to patients, outpatient dialysis units are taking extensive precautions to protect patients and prevent intra-unit spread, making it a safer environment to receive dialysis than the unpredictable hospital setting.

States should pursue adding outpatient dialysis services as allowed benefits of Emergency Medicaid. Changing the scope of Emergency Medicaid does not require new legislation; instead, policy language should be changed to clearly state that outpatient dialysis services encompass all dialysis modalities and vascular access procedures. This would facilitate nation-wide goals to increase the use of home dialysis modalities and arteriovenous fistulas. Mechanisms must be in place to closely monitor health outcomes and document improvements in savings, patient-reported outcomes, or unintended consequences after transition. Importantly, dialysis providers should not be expected to act as agents for the US Immigration and Customs Enforcement Agency by reporting undocumented noncitizens, especially during this public health emergency.

Suspension of the public charge rule is also critical. In addition to a widespread disenrollment in public services, the public charge rule has already caused confusion and fear that discourages immigrant communities from seeking health care

and other critical services. The Coronavirus Immigrant Families Protection Act, introduced April 3, 2020, seeks to suspend the public charge rule and immigration enforcement at sensitive locations. This legislation also seeks to allocate $100 million for the Centers for Disease Control and Prevention to provide language-appropriate public health outreach materials.[16] It will be important for local governments and health systems to provide culturally and linguistically appropriate communication with immigrant communities to provide reassurance about access to care.

Conclusions

We are only as healthy as the most vulnerable among us. Now more than ever, we must protect vulnerable populations and free up inpatient resources however possible. A transition from emergency-only dialysis to standard outpatient dialysis for undocumented immigrants should be a part of larger efforts to increase emergency services, inpatient facilities, and dialysis resources for patients with COVID-19 infection and help stop the spread of COVID-19 in our communities.

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