Dialysis Access for Undocumented Immigrants in Indiana

A report by the Indiana University Robert H. McKinney School of Law Health and Human Rights Clinic

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Executive Summary

End-Stage Renal Disease ("ESRD") disproportionately affects the undocumented immigrant community in the United States. Despite their significant contributions to U.S. communities, including communities in Indiana, undocumented immigrants are blocked from government programs such as Medicare and Medicaid, thus barring ESRD patients’ access to their lifeline: dialysis. The Emergency Medical Treatment and Active Labor Act ("EMTALA") mandates that hospitals receiving Medicare funding provide emergency care to all, regardless of their citizenship status. However, EMTALA does not allow hospitals to receive Medicaid or Medicare reimbursement for providing nonemergency care to undocumented immigrants. Therefore, undocumented ESRD patients are sometimes unable to receive dialysis treatment unless their condition is emergent. In Indiana, undocumented patients must present to the emergency room at the brink of death to receive dialysis pursuant to EMTALA.

In response to this situation, the Health and Human Rights Clinic of the Indiana University Robert H. McKinney School of Law conducted interviews with patients, physicians, and lawmakers, and researched the federal law and other states’ and communities’ approach to this situation, along with the finances of the issue. The emergency-based method for providing dialysis for undocumented immigrants is 3.7 times more expensive than providing scheduled care in an outpatient setting, namely due to frequent and prolonged hospitalizations arising from untreated ESRD complications. Under this emergency-based method, undocumented patients who do not present with qualifying symptoms are turned away. Doctors are forced to make unimaginable decisions regarding who receives treatment or not. This perpetual cycle repeats itself every few days, as the patients reaccumulate enough toxins to reach an emergent condition.

The Personal Responsibility and Work Opportunities Reconciliation Act ("PRWORA") leaves the determination of undocumented immigrants’ access to public benefits to the states. States such as Arizona, California, New York, and North Carolina use state Medicaid funds to sustain scheduled dialysis treatment for undocumented ESRD patients. They have qualified ESRD as an “emergency medical condition” pursuant to EMTALA, triggering Medicaid coverage for outpatient dialysis and ultimately reducing the financial and moral burden of this care. Cities such as Houston and San Antonio have devised municipal tax solutions to fund dialysis for undocumented immigrants with ESRD. Illinois’s designation of ESRD as an “emergency medical condition” has lead to a new law funding kidney transplants for undocumented immigrants with ESRD.

In addition to resolving the needlessly devastating physical consequences of untreated ESRD, the motivation behind these solutions is primarily financial. Indiana should follow the example of states that have dispensed with emergent dialysis and curbed its enormous costs, while still providing the requisite care under EMTALA.
## Definitions

| **ESRD** | *End-Stage Renal Disease* represents the advancement of chronic kidney disease to the point where the patient has permanent kidney failure requiring dialysis or a kidney transplant. Patients with ESRD are in need of dialysis treatments to clean their blood of toxins and remove excess salt and water as well as management of complications such as anemia and bone disease. |
| **Dialysis** | A life-sustaining treatment for ESRD patients that removes waste products and excess fluids from the blood when the kidneys have lost their ability to function. |
| **Hemodialysis** | A blood based dialysis procedure using an artificial membrane to filter the blood that is typically conducted three times a week at an outpatient center. |
| **Peritoneal Dialysis** | A dialysis procedure using the lining of the belly as a filter that is done daily at home. |
| **EMTALA** | The Emergency Medical Treatment and Active Labor Act is a federal law enacted in 1986 that requires hospitals to treat emergency patients, regardless of their citizenship or insurance status. |
| **PRUCOL** | Permanent Residents Under the Color of Law is a designation that renders aliens eligible for Social Security Benefits only if they presently reside in the United States and the Department of Homeland Security has not contemplated enforcing their departure. |
| **PRWORA** | The Personal Responsibility and Work Opportunities Reconciliation Act is a 1996 law that denied full-scope Medicaid benefits to almost all immigrants. |
| **Emergency Medicaid** | Emergency Medicaid provides federally funded emergency medical care for undocumented immigrants through the Social Security Act. |
| **Qualified Aliens** | The following people are designated as qualified aliens: Lawful permanent residents (persons with green cards); Refugees, persons granted asylum or withholding of deportation/removal, and conditional entrants; Persons granted parole by the Department of Homeland Security (DHS) for a period of at least one year; Cuban and Haitian entrants; Certain abused immigrants, their children, and/or their parents; and Certain victims of trafficking. |
| Not-Qualified Aliens | While exceptions exist, “not qualified” aliens are prohibited from receiving most federal public benefits. Undocumented immigrants are considered “not qualified” aliens. “Not qualified aliens also include: temporary residents such as those with time-limited work, study, or travel visas; and individuals with temporary administrative statuses (such as stay of deportation, voluntary departure, individuals paroled for less than one year, and individuals under deportation procedures). |
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I. Suffering Patients in Indiana

A. IMMIGRANTS AND ACCESS TO HEALTHCARE

The U.S. is home to an estimated 11 million immigrants who do not have current authorization to stay in the U.S.\(^1\) An estimated 85,000 undocumented immigrants live in Indiana, a population that exceeds the number of residents in Indiana cities like Bloomington, Lafayette, or Terre Haute.\(^2\)

These undocumented immigrants are ineligible for federally funded government programs like Medicare and non-emergency Medicaid that provide millions of Americans with access to healthcare.\(^3\) Undocumented immigrants are barred from most programs indefinitely, and even lawfully present immigrants typically face five-year waiting periods before they can enroll in those programs.\(^4\)

Compared to U.S. citizens, these immigrants use less healthcare resources and make fewer visits to the emergency room.\(^5\)

Despite the fact that undocumented immigrants are blocked from accessing publicly-funded healthcare programs, those immigrants pay an estimated $108.9 million in taxes annually in Indiana alone,\(^6\) and generate nearly $3 billion each year in economic activity in the state.\(^7\) On a national level,


\(^2\) Id.


\(^4\) Id.


the U.S. government estimates that about half of all undocumented immigrants pay income taxes.\(^8\) Furthermore, Stephen Goss, chief actuary of the Social Security Administration, stated that undocumented immigrants contribute an estimated $15 billion annually to Social Security but only take out about $1 billion per year.\(^9\)

Some opponents of access to healthcare by undocumented immigrants are concerned that providing care outside the scope of what is currently considered emergency care will impose a heavy burden on U.S. taxpayers and encourage medical tourism, which will cause undocumented immigration rates to surge.\(^10\) However, according to the Pew Research Center, California, which has the largest undocumented immigrant population and a legal provision allowing regular dialysis for that population, has not experienced a significant rise in undocumented immigration since 2005.\(^11\) The state has also not experienced an increase in the number of undocumented immigrants receiving dialysis, a result consistent with other locations which have provided dialysis.\(^12\) Although some opponents argue that services such as Emergency Medicaid incentivize undocumented immigration, there is no evidence of such a phenomenon.\(^13\) 

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\(^12\) Grubbs, *supra* note 10.

and reunifying with family members," said Sonal Ambegaokar, a health policy attorney at the National Immigration Law Center.\textsuperscript{14}

**B. END-STAGE RENAL DISEASE AMONG UNDOCUMENTED IMMIGRANTS**

End-stage renal disease ("ESRD") represents the advancement of chronic kidney disease to the point where the patient has permanent kidney failure requiring dialysis or a kidney transplant. Patients with ESRD are in need of dialysis treatments to clean their blood of toxins and remove excess salt and water, as well as management of complications such as severe anemia and bone disease. Typically, dialysis in the US is done three times weekly in an outpatient dialysis unit (hemodialysis).

Alternatively, peritoneal dialysis can be performed daily at home and is the preferred modality in other countries due to its lower cost.\textsuperscript{15} The cost of outpatient hemodialysis is approximately $87,000 annually.\textsuperscript{16} Most patients in U.S. with ESRD are eligible for Medicare, which covers the cost of outpatient dialysis, and the remainder qualify for Medicaid.\textsuperscript{17}

For reasons that seem genetic but are still poorly understood, ESRD is disproportionately present among Mexicans and Mexican-Americans.\textsuperscript{18} Estimates are that the U.S. is home to 6,000 undocumented immigrants in need of dialysis, many of whom came to the U.S. prior to diagnosis of

\begin{footnotesize}
\begin{enumerate}
\item Id.
\item Kuruvilla, Rohit and Garghavan, Rajeev, \textit{Health Care for Undocumented Immigrants in Texas}, Texas Medical Association (July 2014), \url{http://www.texmed.org/July14Journal/}
\item Id.
\item \textit{How to sign up for Medicare if You Have End Stage Renal Disease (ESRD)}, Medicare.gov, \url{http://www.medicare.gov/people-like-me/esrd/getting-medicare-with-esrd.html}
\end{enumerate}
\end{footnotesize}
kidney disease and some are from countries where dialysis would not be available.\textsuperscript{19} Many of those immigrants are excellent candidates for a kidney transplant, as they are disproportionately younger and healthier than U.S. citizen ESRD patients.\textsuperscript{20} They also live longer\textsuperscript{21} and use fewer healthcare resources upon diagnosis.\textsuperscript{22} However, although 1\% of harvested organs come from undocumented persons, that population is usually excluded from receiving transplants.\textsuperscript{23}

C. ACCESS TO DIALYSIS FOR UNDOCUMENTED IMMIGRANTS

Undocumented immigrants’ lack of eligibility for Medicare and most forms of Medicaid presents a severe barrier to proper treatment of ESRD among that population. Some hospitals engage in a process of repatriating patients who present with ESRD.\textsuperscript{24} In Indiana, as in most states, the only path to treatment for undocumented immigrants with ESRD is for those immigrants to present at a hospital emergency room in a state of sufficient crisis that they suffer from an “emergency condition” that qualifies them for temporary treatment under the EMTALA. Those crises include breathing failure from fluid in lungs, heart failure, severely elevated acid levels, severe anemia, and severe electrolyte derangements that can lead to fatal heart arrhythmias.

\textsuperscript{19} Cambell, Adam, Sanoff, Scott, Rosner, Michell, Care of the Undocumented Immigrant in the United States with ESRD, American Journal of Kidney Diseases (September 27, 2009). \url{http://www.ajkd.org/article/S0272-6386(09)00989-5/fulltext}; See also Kuruvilla and Garghavan, supra note 15.


\textsuperscript{22} Nuila, Ricardo. Why Houston Takes Care of Its Own - Papers or No Papers, Houston Chronicle (October 15, 2015), \url{http://www.houstonchronicle.com/local/gray-matters/article/Undocumented-immigrants-The-ER-And-Harris-6535123.php}.

\textsuperscript{23} Gupta, Charu, Immigrants and Organ Sharing: A One-Way Street, 10 AMA Journal of Ethics 229 (2008). \url{http://journalofethics.ama-assn.org/2008/04/msoc1-0804.html}

\textsuperscript{24} Sack, Kevin and Einhorn, Catrin. Deal Would Provide Dialysis to Illegal Immigrants, New York Times (August 31, 2010), \url{http://www.nytimes.com/2010/09/01/health/policy/01grady.html?_r=0}
Providing ESRD care through this process creates a significant cost for the community and the patients. Compared to regularly-scheduled dialysis, emergent dialysis has been shown to be 3.7 times more expensive, due to increased costs of emergency room care and increased numbers of in-patient hospitalizations. The patients and their families suffer from the perpetual cycle of health crises that increase the risk for poor health outcomes and harm the patient’s ability to work. Caregivers report significant strain associated with this practice. As one doctor notes, “These patients are repeatedly brought back from the brink of death only to be released without hope of adequate medical care. We hope they survive until we see them again and hope they survive their next hospital stay.”

There are other models. Arizona, California, New York, North Carolina, and Washington have deemed the need for dialysis to qualify as an “emergency condition” under the EMTALA and provide outpatient dialysis that is covered by Medicaid. San Antonio and Houston have created systems with limited dialysis care for undocumented patients. Illinois’s designation of ESRD as an “emergency medical condition” has led to a new law funding kidney transplants for undocumented immigrants with ESRD. Concerns about the increased treatment options in those locations attracting undocumented immigrants seeking dialysis have proven to be unfounded. The primary drivers of immigration to particular locations are employment and family. Many hold the popular belief that


Kuruvilla and Garghavan, supra note 15.

See, generally, Coritsidis et al., supra note 11.

Galewitz, Phil, Medicaid Helps Hospitals Pay for Illegal Immigrants’ Care, Kaiser Commission, (February 12, 2013), http://khn.org/news/medicaid-illegal-immigrant-emergency-care/, (“There is no evidence that Emergency Medicaid is the cause of migration…Immigrants migrate to the U.S. for job opportunities and reuniting with family members.”).
the motivation behind the ESRD patients’ immigration to the United States was to seek treatment for their condition. However, this notion is dispelled by quantitative and anecdotal evidence. For example, a study conducted in a Houston dialysis unit indicated that more than 95% of its undocumented ESRD patients progressed to ESRD while living in the United States.\textsuperscript{31} In the course of interviews with the IU McKinney Law Health and Human Rights Clinic, several ESRD patients currently receiving emergent treatment stated they immigrated to the United States (and to Indiana specifically) for familial and economic purposes.\textsuperscript{32} When asked whether they have considered moving to other states with more favorable dialysis coverage for undocumented immigrants, they indicated that they had entertained the idea but decided against it.\textsuperscript{33} Although they are aware that certain states provide better coverage, they cited family and the life that they have established in Indiana as their reasons for not moving.\textsuperscript{34}

**D. UNDOCUMENTED ESRD PATIENTS’ ACCESS TO DIALYSIS IN INDIANA**

Most undocumented immigrants in need of dialysis are directed by medical professionals to safety net hospitals with the hopes of securing scheduled dialysis for their desperate patients. Unfortunately, Indiana has no provision for these patients regardless of location. Safety net hospitals are left to devise their own solutions while weighing patient care with limited resources. In Indianapolis, these solutions range from provision of unreimbursed scheduled dialysis as charity care to strict emergency-only care with inpatient and sometimes ICU-level care. The benefit to the scheduled dialysis model is

\begin{footnotesize}

\textsuperscript{32} Transcript, Personal Interview with K. Voskoboynik, April 2015, Indianapolis, Indiana.

\textsuperscript{33} \textit{Id.}

\textsuperscript{34} \textit{Id.}
\end{footnotesize}
less utilization of emergency and ICU resources as well as better patient outcomes and health but is a cost the hospital must absorb. With growing immigrant numbers, it is not sustainable.

B, a thirty-three year-old immigrant from El Salvador receiving emergent dialysis at a safety net hospital, held a steady job at a fast food restaurant while undergoing scheduled treatment under a former policy. After the safety net hospital altered its prior emergency-based practice of treating ESRD, he lost his job due to the irregularity of the schedule and the symptoms arising from inconsistent ESRD treatment. B stated that several fellow patients faced the same predicament. S, a twenty-six year old immigrant from Mexico receiving emergent dialysis at a safety net hospital, held a steady job at a grocery store for several years after her ESRD diagnosis, but was also unable to continue after the policy change. This is consistent with Houston data showing more immigrants with ESRD are employed compared to US citizens on dialysis, provided they are not too sick from irregular dialysis to work.

Using the “emergency circumstances only” model of dialysis care, patients are told that “they must be on the brink of death” to receive dialysis through the emergency room. To obtain admission and receive dialysis, patients must present with symptoms such as “breathing failure, life threatening acid levels, severe anemia, heart arrhythmias, confusion/lethargy, catheter infections, and bleeding problems.” S describes that some of the symptoms she must present to be admitted are shortness of

36 Id.
37 Id.
38 Transcript, Personal Interview with K. Voskoboynik, April 2015, Indianapolis, Indiana
40 Transcript, Personal Interview with K. Voskoboynik, April 2015, Indianapolis, Indiana
breath, vomiting, and fainting. She previously received treatment two to three times a week, but now only comes to the emergency room when she feels very ill (typically once a week). Since the implementation of a new hospital policy, S has been refused treatment twice because her condition did not qualify as emergent.

The devastating symptoms caused by irregular treatment result in extended hospital stays, often in the ICU. The patients are now unable to work, suffer dangerous and uncomfortable symptoms (that are avoidable with scheduled dialysis), and experience familial hardship arising from the irregular schedule prompted by emergent dialysis.

B recounts

“Before the changes in the hospital, everything was fine. Now it’s much more difficult, because we arrive, we are in a very bad condition. Previously, we could come two to three times a week and receive four hours of dialysis. Then we could leave. When I used to come two to three times a week, I didn’t have any symptoms. We could get treatment when we needed it. Now, we have to suffer and come in vomiting. Otherwise, they turn us away. Since they have reduced my dialysis, I experience pain, nausea, difficulty eating, itchiness, and a lot of suffering. I’m in so much pain that I can’t sleep. I tell the doctors about these symptoms, and the only thing they say is that I need more dialysis. It’s very sad, and there are no words to describe living like this.”

The enormous toll on patients’ families is an invisible consequence of emergency-only dialysis care. B describes the difficulty that the irregular schedule poses on his family, as they sometimes have to change their work schedules or shorten their hours to transport him to and from the hospital.

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41 Id.  
42 Id.  
43 Transcript, Personal Interview with K. Voskoboynik, July 2015, Indianapolis, Indiana.  
44 Id.  
45 Id.
When B received dialysis more frequently, he was able to assist with familial responsibilities, such as accompanying his nieces and nephews to and from the bus stop. The extended hospital stays now prevent him from doing so. Regarding the impact of emergency-only dialysis care on his family, B states “There is no will to live, because you know you’re hurting your family.”

Although S experiences painful symptoms from the reduction of her treatments, her chief complaint with the new policy is its interference in raising her six year-old son. S states “I don’t have anybody to take care of my son. Everyone works. When I’m at the hospital, I can’t do anything. My son says “mommy, don’t go to the hospital.” S commented that emergency-only dialysis care is very difficult for women with children, because they must find someone to care for their children during long hospital stays.

Social work staff working with “illegal” ESRD patients noted that that some of the patients were in the following situations: legal immigrants but ineligible for benefits, previously legal immigrants with lapsed visas, and legal but unaware that they could obtain healthcare. However, undocumented immigrants pay taxes and contribute significantly to Indiana’s economy. As a result, they pay into healthcare programs whose benefits they are ineligible to receive. In 2010, undocumented immigrants in Indiana paid $108.9 million in state and local taxes. This number includes $74.4 million in sales taxes, $25.4 million in state income taxes, and $9 million in property taxes.

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46 Id.
47 Id.
48 Id.
49 Transcript, Personal Interview with K. Voskoboynik, April 2015, Indianapolis, Indiana.
50 Id.
51 Anderson, supra note 39.
52 Institute on Taxation and Economic Policy, supra note 6.
Interestingly, if undocumented immigrants were granted legal status, they would contribute $141.7 million in state and local taxes, including $78.8 million in sales taxes, $53.3 million in state income taxes, and $9.6 million in property taxes. However, the removal of all undocumented immigrants from Indiana would result in the state’s loss of $2.8 billion in economic activity, $1.3 billion in gross state product, and approximately 16,739 jobs.\(^{54}\)

II. Existing Law on Access to Care

A. BACKGROUND

1. Overview

The barriers that stop immigrants from accessing healthcare were created by legislation. In 1972, a federal law was enacted that ensured ESRD patients’ access to treatment, regardless of their citizenship status. In 1986, the Omnibus Reconciliation Act barred the spending of federal funds towards undocumented immigrants, unless they required emergency care. Congress then passed EMTALA, mandating that hospital receiving Medicare funding provide emergency care to all irrespective of their immigration status, but preventing them from providing nonemergency medical services to undocumented immigrants. The 1996 Personal Responsibility and Work Opportunity Reconciliation Act, billed as ending “welfare as we know it,” contained provisions that blocked undocumented immigrants from access to many public benefits, including the health insurance program Medicaid.\(^{55}\) The Affordable Care Act excludes undocumented immigrants from its expanded coverage, including barring them from Medicare, non-emergency Medicaid, and from purchasing

\(^{53}\) Id.

\(^{54}\) Perryman Group, supra note 7.

insurance through the state or federal health insurance exchanges.\textsuperscript{56} Similarly, many immigration reform efforts and proposals, such as the Border Security, Economic Opportunity, and Immigration Modernization Act of 2013 and President Obama’s executive orders on deferred action, do not expand healthcare coverage for undocumented individuals.\textsuperscript{57}

2. The Medicaid Act and PRUCOL

In 1965, Congress enacted The Medicaid Act (the “Act”), and the Department of Health and Human Services (“HHS”) interpreted that the Act applies to noncitizens.\textsuperscript{58} However, in 1973, Congress amended the Social Security Act to no longer extend Social Security benefits to noncitizens.\textsuperscript{59} In 1990, the HHS issued a regulation restricting the availability of Medicaid services to legal permanent residents or Permanent Residents Under the Color of Law (“PRUCOL”).\textsuperscript{60} PRUCOL is a designation that renders aliens eligible for Social Security Benefits only if they presently reside in the United States and the Department of Homeland Security (“DHS”) has not contemplated enforcing their departure.\textsuperscript{61} As a result of this regulation, undocumented immigrants who were not legal permanent residents or PRUCOL were excluded from receiving Medicaid and Social Security benefits.

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\textsuperscript{58} Jane Perkins, Medicaid Coverage of Emergency Medical Conditions: An Update, National Health Law Program (May 7, 2007); at the time HHS was called the Department of Health, Education, and Welfare.

\textsuperscript{59} Id. at 3.


\textsuperscript{61} See Berger v. Heckler, 771 F2d 1556 (1985).
3. PRWORA

In 1972, Congress amended the Medicaid statute to provide funding for an “emergency medical condition” regardless of immigration status. Immigrant eligibility for Medicaid was substantially altered in 1996, when Congress enacted the Personal Responsibility and Work Opportunities Reconciliation Act (“PRWORA”). This act denied full-scope Medicaid benefits to almost all immigrants. Two categories of immigrants for benefit eligibility purposes emerged from PRWORA: “qualified aliens” and “not qualified aliens.” However, the law excludes many members of both groups from benefit eligibility. The following people are included in the qualified immigrant category: Lawful permanent residents (persons with green cards); Refugees, persons granted asylum or withholding of deportation/removal, and conditional entrants; Persons granted parole by the Department of Homeland Security (“DHS”) for a period of at least one year; Cuban and Haitian entrants; Certain abused immigrants, their children, and/or their parents; and Certain victims of trafficking. Immigrants are not entitled to benefits while United States Citizenship and Immigration Services (“USCIS”) determines their status. Therefore, immigrants actively pursuing legal status are not eligible for benefits, and the process may take years.

Undocumented immigrants are considered “not qualified” aliens. Temporary legal residents such as those with time-limited work, study, or travel visas are also “not qualified” aliens.

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62 Perkins, supra note 58 at 3.
63 Perkins, supra note 58 at 3.
64 Id.
65 Id.
66 Id.
67 Id.
68 Id.
Additionally, individuals with temporary administrative statuses (such as stay of deportation, voluntary departure, individuals paroled for less than one year, and individuals under deportation procedures) are considered “not qualified” aliens.\(^69\) Congress created a new category of noncitizens in 2000.\(^70\) Victims of trafficking are eligible for federal public benefits in the same regard as refugees, regardless of whether they are “qualified” or not.\(^71\) In 2003, Congress established that “derivative beneficiaries” on trafficking victims’ visa applications, such as spouses, children, parents, and minor siblings, may also be eligible for federal benefits.\(^72\)

While exceptions exist, “not qualified” aliens are prohibited from receiving most federal public benefits.\(^73\) Although the welfare law does not specifically identify the programs included in federal public benefits, they are defined as “safety-net services paid for by federal funds.”\(^74\) In 1998, HHS issued a clarifying notice stating which programs are included in the federal public benefit definition.\(^75\) The notice listed 31 total programs, which includes: Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, Temporary Assistance for Needy Families (TANF), Foster Care, Adoption Assistance, the Child Care and Development Fund, and the Low-Income Home Energy Assistance Program.\(^76\)


\(^70\) Id.

\(^71\) Id.

\(^72\) Id.

\(^73\) Id.

\(^74\) Id.

\(^75\) US Dep’t of Health and Human Services, *supra* note 69.

\(^76\) Id.
As previously stated, exceptions exist that permit “not qualified” aliens to secure certain federal public benefits.77 For example, “not qualified aliens” may receive emergency Medicaid if they are otherwise eligible for their state’s Medicaid program.78 They are also able to access public health programs that provide immunization and communicable disease symptom treatment, and may qualify for community or county-based healthcare programs as well.79 Children are also eligible for school breakfast and lunch services, regardless of whether they are “qualified” aliens or not.80 Additionally, access exists to the Special Supplemental Nutrition Program for Women, Infants, and Children regardless of immigration status.81 “Not qualified” aliens are eligible for “Short-term non cash emergency disaster assistance” as well as other life or safety protection services, as long as no individual or household income qualification requirement exists.82 The benefits that meet this definition include: “shelters, soup kitchens, and meals-on-wheels; medical, public health, and mental health services necessary to protect life or safety; disability or substance abuse services necessary to protect life or safety; and programs to protect the life or safety of workers, children and youths, or community residents.”83


78 Id.

79 Id at 38.

80 Id. at 37.

81 Id. at 49.


83 Id.
4. Restriction of Federal Public Benefits after PRWORA

Prior to the PRWORA, lawfully residing immigrants enjoyed similar eligibility for federal public benefits as U.S. citizens. However, after the laws’ enactment, “qualified” aliens were prevented from receiving services from many federal benefits programs for five years or longer. The restrictions are applicable to the following federal benefits programs: Medicaid (except for emergency care), CHIP, TANF, food stamps, and SSI. Consequently, immigrant participation in the federal benefits programs plummeted, “causing severe hardship to many low-income families who lacked the support available to other low-income families.” Approximately one half of states have undertaken to supplement the diminished coverage of lawful permanent residents through state funds. While certain states and counties provide healthcare services to children and/or pregnant women without regard to their immigration status, many state programs that benefited immigrants have been truncated or extinguished due to budget constraints.

Federal agencies are required to verify the immigration and citizenship status of applicants when they specify a federal public benefit program that bars “not qualified” aliens from receiving services. However, various federal agencies have not designated which programs are for federal public benefits purposes. As a result, they are not required to verify the immigration and citizenship

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84 Id.
85 Id.
86 Id.
87 Id.
88 National Immigration Law Center, supra note 82.
89 Id.
90 Id.
91 Id.
status of applicants. Additionally, nonprofit charitable organizations are not obligated to verify “proof of eligibility” for applicants to receive benefits.\textsuperscript{92}

States can obtain federal funding for TANF, Medicaid, and CHIP services for aliens who complete the five-year bar and secure qualified immigrant status.\textsuperscript{93} The following categories of people are exempt from the five-year ban on federal public benefits: refugees, persons granted asylum or withholding of deportation/removal, Cuban/Haitian entrants, certain Amerasian immigrants, Iraqi and Afghan Special Immigrants, and victims of trafficking, “qualified” immigrant veterans, active duty military, and their spouses and children.\textsuperscript{94}

As of Congress’s reauthorization of the CHIP Program in February 2009, states are permitted to provide federally funded Medicaid and CHIP to pregnant women and children lawfully residing in the United States, regardless of when they entered the United States.\textsuperscript{95} Nearly half of the states utilize this funding to provide health coverage for immigrants.\textsuperscript{96}

**B. FEDERAL LEGISLATION AND EMERGENCY MEDICAID**

Federally funded Medicaid is only available to undocumented immigrants in emergency situations. This is especially problematic because 29\% of the immigrant population is undocumented and the cost associated with emergency care for this population accounts for a large portion of the funds spent on emergency services each year.\textsuperscript{97} Two statutes provide this coverage. The Emergency

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\textsuperscript{92} Id.

\textsuperscript{93} Id.

\textsuperscript{94} National Immigration Law Center, supra note 82.

\textsuperscript{95} Id.

\textsuperscript{96} Id.

\textsuperscript{97} Perkins, supra note 58 at 1. (“Officials in ten states surveyed by the United States General Accounting Office reported that most of the $2 billion they spent on emergency Medicaid services in fiscal year 2002 was attributable to undocumented aliens, particularly pregnant women’s labor and delivery services.”)
Medical Treatment and Labor Act (EMTALA) delineates a hospital’s responsibilities when a person presents to the emergency room, and the Emergency Medicaid statute provides federal funding for treatment.

1. EMTALA

One source of public healthcare for undocumented immigrants derives from the 1986 Emergency Medical Treatment and Labor Act (EMTALA). EMTALA is codified at 42 U.S.C.A. § 1395dd, and was enacted in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (“COBRA”)98. EMTALA requires treatment and stabilization of any individual entering an emergency room, regardless of their immigration or insurance status.99 Congress adopted the statute in order to prevent “patient dumping,” which occurs when a patient who was unable to pay for medical care is transferred to a public hospital.100 EMTALA applies to all Medicaid participating hospitals with emergency departments.101 This includes 98% of hospitals in the United States.102 The statute provides for emergency services for “any individual; (whether or not eligible for benefits under this subchapter).”103 EMTALA requires hospitals to first perform an initial medical screening to determine if an emergency situation exists; second, to stabilize the condition of the patient with staff and facilities available or transfer the person to another facility; and finally, the statute requires


100 Id.


102 Zibulewsky, supra note 98, at 340.

103 42 U.S.C.A. § 1395dd.
hospitals with specialized capabilities to accept patients that need special care. Hospitals are not allowed to delay care in order to ascertain an individual’s immigration status.

Failure to follow these guidelines can result in civil penalties for both the physician and the hospital. The hospital can be fined up to $50,000 per case for a negligent violation of EMTALA, and physicians can also be fined up to $50,000. In 2000, Congress prioritized the enforcement of EMTALA, leading to a substantial increase in the number of fines. Hospitals and physicians must ensure they are providing appropriate emergency medical care to any patient who enters the hospital, including undocumented immigrants.

The EMTALA statute includes a definition of what constitutes an emergency medical condition. There are similar definitions elsewhere in the Social Security Act and the Centers for Medicare and Medicaid Services (CMS). This has created ambiguity on what situations are classified as emergent. The litigation section of this paper will discuss this in further detail, as courts and the states have varying outlooks on whether routine dialysis can qualify as an emergency medical condition. Under EMTALA, an emergency medical condition is defined as "a condition 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 individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."
In addition to the lack of consensus on what constitutes an emergent medical condition, EMTALA also encounters issues arising from lack of funding. Some consider EMTALA an unfunded mandate on hospitals. The American Medical Association estimates that emergency physicians each provide an average of $138,300 in EMTALA charity care each year.

Figure 1: Uncompensated Care as a Fraction of National Health Expenditures

![Uncompensated Care as a Fraction of National Health Expenditures](Photo Credit: Forbes)

2. Emergency Medicaid

The Social Security Act also provides federally funded emergency medical care for undocumented immigrants through Emergency Medicaid. Section 1396b(v)(2) of the Social Security Act states that funding for emergency services will be provided only if:

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111 American College of Emergency Physicians, supra note 108.

“(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, (B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV of this chapter, supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment), and (C) such care and services are not related to an organ transplant procedure.”

The statute provides a definition of “emergency medical condition” that is substantially similar to the definition included in the EMTALA statute. The section 1396(v)(3) definition states that an emergency medical condition

“means 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.”

To receive funding pursuant to this statute, an undocumented person must suffer from an emergency medical condition, and must qualify for Emergency Medicaid in that state. These requirements often present a problem for undocumented immigrants. Most states have residency and income requirements, and the federal rules also require residency in the state where the individual is applying for aid. In Indiana, Medicaid eligibility includes income, residency, citizenship status, and household composition.

113 42 U.S.C. §1396b(v)(2).
114 42 U.S.C. §1396b(v)(3).
115 Perkins supra note 58 at 4.
Undocumented immigrants have been denied emergency Medicaid based on residency, and courts have routinely upheld these decisions.\textsuperscript{117} For example, in \textit{Okale v. N.C. Dep’t of Health and Human Svcs.} a North Carolina court upheld the denial of emergency Medicaid to a woman based on residency even though she had a lease agreement, a checking account, an identification card, and a driver’s license in North Carolina.\textsuperscript{118} The court concluded that her temporary tourist visa created doubt regarding her intention to remain in North Carolina.\textsuperscript{119} However, in \textit{St. Joseph’s Hospital and Medical Center v. Maricopa County}, the court held that undocumented immigrants can qualify as county residents for purposes of reimbursing a hospital for providing emergency care.\textsuperscript{120} In \textit{St. Joseph’s}, three undocumented immigrants receiving emergency care were considered residents because they were in “Arizona to reside permanently, and . . . at least for the time being, entertain[ed] no idea of having or seeking a permanent home elsewhere.”\textsuperscript{121} The court reasoned that residence is “primarily a state of mind combined with actual physical presence in the state,” thus ruling that the three undocumented immigrants satisfied this requirement.\textsuperscript{122}

In addition to meeting the residency requirements, another barrier non-citizens face is a request for a social security number when a non-citizen applies for emergency medical services.\textsuperscript{123} Federal law does not require a social security number, and federal regulations explicitly state that such a

\textsuperscript{117} Perkins \textit{supra} note 58 at 4.

\textsuperscript{118} 570 S.E.2d 741 (N.C. App. 2002).

\textsuperscript{119} \textit{Id.} at 745.

\textsuperscript{120} \textit{St. Joseph’s Hospital and Medical Center v. Maricopa County}, 142 Ariz. 94 (1984).

\textsuperscript{121} \textit{Id.} at 99

\textsuperscript{122} \textit{Id.}

\textsuperscript{123} Perkins \textit{supra} note 59 at 5.
requirement should not exist.\textsuperscript{124} States such as California, Massachusetts, and Washington have avoided this problem by pre-certifying individuals for emergency Medicaid.\textsuperscript{125}

Another source of funding exists through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).\textsuperscript{126} The MMA set aside one billion dollars to reimburse hospitals for uncompensated expenses, and section 1011 specifically reimburses hospitals for services provided to undocumented immigrants.\textsuperscript{127} Unfortunately, as of November 25, 2014, Indiana and twenty-nine other states have exhausted the resources set aside by section 1011.\textsuperscript{128} The requirements of EMTALA and the limited availability of funds through the Social Security Act result in hospitals providing unfunded and unreimbursed care.\textsuperscript{129}

\section*{C. CASE LAW}

The definition of an emergency medical condition is unclear under the Medicaid statute, and has resulted in varying interpretations across the country. Courts and states are divided on what constitutes “emergency care” in a long-term care scenario such as dialysis. Some courts have interpreted “emergency care” to include routine treatment such as dialysis, while others have refrained from concluding that dialysis is emergent care.

In Greenery Rehab. Grp., Inc. v. Hammon, the Greenery Rehabilitation Hospital agreed to admit three undocumented immigrants with severe brain injuries.\textsuperscript{130} The 2\textsuperscript{nd} Circuit interpreted 42

\begin{thebibliography}{99}
\bibitem{124} Id. at 6.
\bibitem{125} Id.
\bibitem{126} Morgan Greenspon, \textit{The Emergency Medical Treatment And Active Labor Act And Sources Of Funding}, Annals of Health Law, Vol. 17 [2008], Iss. 2, Art. 9, 314.
\bibitem{127} Id.
\bibitem{128} Novitas Solutions, \textit{Section 1011 Program Information: Spent Down States}, http://www.novitassolutions.com/webcenter/portal/Section1011/pagebyid?_afirLoop=555843480188000&_adf.ctrl-state=yk9wvpidh_17&contentId=00004508#!
\bibitem{129} See Greenspon, supra note 126.
\bibitem{130} 150 F.3d 226 (2d Cir. 1998).
\end{thebibliography}
U.S.C. § 1396b(v)(3)’s “emergency medical condition” definition as “unambiguously convey[ing] the meaning that emergency medical conditions are sudden, severe and short-lived physical injuries or illnesses that require immediate treatment to prevent further harm.”\footnote{131} The court declined the argument that the CMS regulation defining emergency medical condition required that the phrase be read liberally, and that it encompassed ongoing care.\footnote{132} Consequently, the undocumented immigrants’ care in the rehabilitation hospital was not covered by emergency Medicaid.\footnote{133}

In \textit{Quiceno v. Dep't of Soc. Servs.}, a Connecticut court held that “permanent dialysis treatment was not emergency medical treatment for Medicaid assistance purposes.”\footnote{134} In \textit{Quiceno}, an undocumented woman suffered from end stage renal disease stemming from a lupus diagnosis.\footnote{135} The Connecticut Department of Social Services denied Medicaid payments for her dialysis treatment, reasoning that it was not an “emergency medical condition.”\footnote{136} The court agreed with the Department, and held that because the treatments were “continued and regimented,” similar to the plaintiffs’ treatments in the \textit{Greeley} case, the woman’s dialysis treatment was not an emergency.\footnote{137} The court also opined that the fatal consequences of stopping the treatment did not trigger an emergency classification.\footnote{138} The court stated that its ruling was consistent with other authority

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\begin{itemize}
  \item \footnote{131} \textit{Id.} at 232.
  \item \footnote{132} \textit{Id.} at 233.
  \item \footnote{133} \textit{Id.}
  \item \footnote{134} 728 A.2d 553, 553 (Supr. Ct. 1999).
  \item \footnote{135} \textit{Id.} at 554.
  \item \footnote{136} \textit{Id.}
  \item \footnote{137} \textit{Id.} at 555.
  \item \footnote{138} \textit{Id.}
\end{itemize}
holding that Medicaid coverage is limited in scope. The woman died during the course of the court case.

Nevertheless, other courts have interpreted “emergency medical condition” broadly. In *Gaddam v. Rowe*, the same Connecticut court that later denied dialysis on an emergency basis in *Quiceno* had previously reached a different conclusion. The plaintiff in *Quiceno* relied on this case, but the court simply responded that *Gaddam* did not control, and offered no further explanation. In *Gaddam*, an Indian student studying abroad in the United States was diagnosed with kidney disease and required dialysis. The court determined whether he could continue to receive dialysis as an outpatient. The court held that:

> “The narrow issue in the present case is whether an alien who is entitled to Medicaid payments for medical treatment loses that entitlement as soon as the acute symptoms that precipitated the medical treatment dissipate, even though the symptoms will quickly reoccur and will result in death in less than two weeks if that medical treatment is halted.”

The court concluded that the treatments should continue, despite making the situation less acute. The court also noted that “[g]iven the potential for the plaintiff's death and the charitable nature of the gift of dialysis which can be terminated at any time, the action of this court is not stayed pending appeal, and payments under Medicaid shall resume.”

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139 *Id.*
140 *Id.*
141 684 A.2d 286 (Supr. Ct. 1995)
142 *Id.*
143 *Id.* at 273.
144 *Id.* at 287.
145 *Id.* at 273.
146 *Id.* at 273.
In Arizona, a court considered whether an undocumented immigrant’s continued care at a nursing home facility was covered by Medicaid. *Mercy Healthcare Arizona, Inc. v. Arizona Health Care Cost Containment Sys.* involved an undocumented immigrant who was injured in a car accident.\(^1\) The hospital transferred the man, who was in a non-verbal state, unable to move his legs, and had a feeding tube, to a skilled nursing facility.\(^2\) The facility sought to have his continued care covered by Arizona’s Medicaid statute.\(^3\) The court ruled that Medicaid covered the man’s care, because the statute required that the Arizona agency “cover services for treatment of that medical condition so long as absence of immediate treatment for that condition could reasonably be expected to result in “one of the three consequences defined by statute.”\(^4\) Interestingly, Arizona previously covered medical care for undocumented immigrants under its own state funded Medicaid program. In 1993, the state legislature amended this to only cover emergencies as defined by the Social Security Act.

### III. How Other States Address This Issue

#### A. ARIZONA

In 2002, Senator John McCain cosponsored the “Federal Responsibility for Immigrant Health Act of 2002,” a bipartisan bill that would permit states and health care providers to obtain Medicaid reimbursement for dialysis, chemotherapy, and other treatment provided to immigrants.\(^5\) The bill would provide federal funding for immigrant medical care; an expense being shouldered by state and

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\(^1\) 887 P.2d 625 (Ct. App. 1994).
\(^2\) *Id.*
\(^3\) *Id.*
\(^4\) *Id.*
\(^5\) *Id.* at 629.

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local governments. A study conducted by the AZ Hospital and Healthcare Association revealed that in 2001, healthcare for immigrants cost Arizona hospitals more than $44 million in uncompensated care. The bill posited that dialysis and chemotherapy served to treat life-threatening conditions, therefore qualifying these services as emergency care and eligible for Medicaid reimbursement. When announcing the bill, Sen. McCain stated “this bipartisan bill provides critical support to our states and localities, including the medical community, for the costs they incur while providing healthcare ensuring that access to critical services. . .[is] available for our most vulnerable populations. . .As a border state, Arizona's hospitals have been hit especially hard by the cost of medical services provided to immigrants...This legislation would provide Arizona and other states with federal money for immigrant medical care.”

The bill ultimately failed, and “what’s left is an ambiguous policy the federal government has struggled to clarify.” After the federal government determined that dialysis is not considered emergency care in 2001, the Arizona Health Care Cost Containment System (“AHCCCS”), Arizona’s Medicaid agency, attempted to halt dialysis treatment for immigrants. Before the AHCCCS’s policy change in 2002, persons with ESRD received dialysis as an emergency service. The William E. Morris Institute for Justice and the Arizona Center for Disability Law sued the AHCCCS in 2002, alleging that dialysis is an emergency service that would be withheld from over 250 patients in the

152 Id.
153 Id.
154 Id.
155 Id.
state due to the policy change. The agency and the plaintiffs reached a settlement in 2007, stating that the AHCCCS will provide dialysis as an emergency service to all undocumented ESRD patients in Arizona. While the settlement only permits emergent dialysis on a weekly basis, it exemplifies how an agency interpretation (whether spurred by a lawsuit or not) can effectuate change in the context of dialysis access for undocumented immigrants.

**B. CALIFORNIA**

In California, undocumented immigrants are able to receive limited California Medicaid (MediCal) benefits. These benefits include services for emergencies and pregnancy, but also “state-funded long-term care.” The limited benefits reach beyond what federal Medicaid will provide, and include non-emergency pregnancy and dialysis care. The statute specifically addresses dialysis treatment, stating that:

“All aliens who were receiving long-term care or renal dialysis services (1) on the day prior to the effective date of the amendment to paragraph (1) of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 at the 1991-92 Regular Session of the Legislature and (2) under the authority of paragraph (1) of subdivision (f) of Section 1 of Chapter 1441 of the Statutes of 1988 as it read on June 30, 1992, shall continue to receive these services. The authority for continuation of long-term care or renal dialysis services in this subdivision shall not apply to any person whose long-term care or renal dialysis services end for any reason after the effective date of the amendment described in this subdivision.”

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158 *Id.*


This statute was the basis of extensive litigation in Crespin v. Kizer, where the court engaged in statutory interpretation to determine the availability of long-term care and renal dialysis under Medi-Cal. When Congress limited the availability of Medicaid for undocumented immigrants to only those who were legal residents or PRUCOL in 1973, California responded by enacting its own legislation, Cal. Welf. & Inst. Code § 14007.5. The lawsuit arose out of the California Department of Health Care Services’s interpretation of the dialysis requirements of the statute. The Department interpreted the statute to state that “aliens needing long-term care or renal dialysis who applied after October 1, 1988, would not receive any assistance seeking PRUCOL status and were entitled only to restricted benefits unless they could provide proof of satisfactory immigration status.”

The court enjoined the Department from denying coverage for dialysis based on immigration status, preventing it from:

“[d]oing any of the following as to aliens seeking Medi–Cal coverage of long-term care or kidney dialysis services after October 1, 1988, and who did not receive Medi–Cal coverage of services on that date: (a) Failing to initiate verification (including secondary verification, if necessary) with the [INS] of such persons’ status as ... [PRUCOL], or otherwise possessing satisfactory immigration status ...; (b) Failing to provide assistance in obtaining PRUCOL status, or other [satisfactory immigration status], that is ordinarily given to aliens receiving Medi–Cal coverage of long-term care or kidney dialysis services on or before October 1, 1988; (c) Denying full-scope Medi–Cal coverage on the basis of citizenship or immigration status while awaiting the outcome of INS verification and the completion of all applicable notice and hearing procedures; [and] (d) Denying coverage of medically necessary renal dialysis services or long-term care services for patients ultimately not found PRUCOL or otherwise possessing [satisfactory immigration status], but who are otherwise eligible for Medi–Cal.”

163 Kizer, supra note 60, at 575.
164 Id.
165 Id. at 583.
The court based its opinion in part on the idea that the state would not shoulder the burden of the cost of the treatment because most aliens could likely qualify as PRUCOL. The Department argued that one of the purposes of the Medi-Cal statute was to maximize the amount of federal funding to California. The court found that the construction of the statute, which provides for long-term care and dialysis for all immigrants, is consistent with this goal. The court noted that the statute requires the Department to assure that the person qualifies as PRUCOL in order to get federal financial participation, which creates a state-funded safety net for those aliens who do not qualify as PRUCOL and whose dialysis does not qualify as an emergency medical condition.

Currently, undocumented immigrants in California with ESRD are able to receive outpatient dialysis three times a week. This program is largely state funded, but the Department interprets the statute as funding dialysis only for situations where the dialysis is not federally covered as an “emergency condition.” This case was decided prior to the enactment of PRWORA, when PRUCOL aliens could still qualify for federally funded Medicaid benefits. Despite the change in funding, the state is still providing dialysis to undocumented immigrants.

C. Illinois

Illinois defines kidney failure as being in a constant state of emergency, so it committed to providing dialysis for the rest of ESRD patients’ lives, rather than just providing dialysis in

\[166\] Id.
\[167\] Id.
\[168\] Id.
\[170\] Id.
emergency room situations, at a cost of about $60,000 per patient per year.\(^{171}\) The Illinois State Chronic Renal Disease Program was established by statute in 1967 by the Illinois Department of Healthcare and Family Services.\(^{172}\) The program assists Illinois residents who have been diagnosed with ESRD but do not qualify for Medicaid or All Kids or cannot meet spend down.\(^{173}\)

Although the program is not available as emergency medical services to ineligible non-citizens, it is available to residents of Illinois.\(^{174}\) A resident is defined as someone who has established his permanent home in Illinois by purchasing, renting, or making other arrangements for housing facilities that he uses as his home; has household equipment, furnishings, and personal belongings in the home; is seeking employment or is engaged in other self-support activity, or if he cannot work, is supported by other means.\(^{175}\) If the individual moves out of Illinois for the purpose of finding employment or other means of support, he will retain his Illinois residence eligibility for 12 months unless he has acquired residence eligibility for public aid in another state.\(^{176}\) If the individual is a non-citizen, he must fall into one of several categories, including but not limited to the following: persons for whom deportation has been withheld under the Immigration and Nationality Act; persons granted conditional entry under the Immigration and Nationality Act as in effect prior to April 1, 1980; persons lawfully admitted for permanent residence under the Immigration and Nationality Act; and parolees for at least one year under the Immigration and Nationality Act.\(^{177}\)

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\(^{175}\) 305 ILCS 5/2-10 (2015).

\(^{176}\) Id.

\(^{177}\) 305 ILCS 5/1-11 (2015).
Patients participating the program must also meet the requirements of the Patient Protection and Affordable Care Act and pay a monthly participation fee to the facility from which they receive dialysis.\textsuperscript{178} Covered services under this program include dialysis treatments received in a dialysis treatment center, dialysis treatments received in the hospital outpatient setting, and home dialysis treatments.\textsuperscript{179} The program may also cover costs associated with prescribed medication related to chronic renal disease treatment and transportation to and from the site of dialysis in emergency situations.\textsuperscript{180}

**D. NEW YORK**

In New York, undocumented aliens qualify for emergency Medicaid and receive benefits for emergency services only or they can receive full benefits if they are determined to be PRUCOL. Undocumented immigrants who are classified as PRUCOL are eligible for “all of the State’s medical assistance programs.”\textsuperscript{181} This resulted from *Aliessa ex rel. Fayad v. Novello*, decided in 2001 after Congress enacted PRWORA. In *Aliessa ex rel. Fayad*, the New York Court of Appeals concluded that the law enacted by New York mirroring the federal PRWORA violated the New York state constitution.\textsuperscript{182} This ruling “restor[ed] Medicaid coverage in New York State to both lawful permanent residents who came to the United States on or after August 22, 1996 and PRUCOLs regardless of when they entered the U.S.”\textsuperscript{183} For immigrants residing in New York who are not PRUCOL, Emergency Medicaid is available for those who would be eligible for Medicaid if not for their


\textsuperscript{180} *Id.*


\textsuperscript{182} 754 N.E.2d 1085 (N.Y. Ct. App. 2001).

immigration status, as long as they are a resident of New York and are suffering from an emergency medical condition as defined by 42 USC § 1396b(v)(3).\textsuperscript{184}

E. NORTH CAROLINA

North Carolina offers two avenues for undocumented immigrants to receive emergency Medicaid coverage.\textsuperscript{185} The first way to obtain coverage is through the Medicaid Assistance for Families program, where one must fulfill residency and income requirements, and be a caretaker of a Medicaid-eligible child (this typically means they were born in the U.S.).\textsuperscript{186} The second route is through the Adult Medicaid program, where one must fulfill residency and income requirements, and have a permanent disability.\textsuperscript{187} North Carolina also expressly provides that dialysis is an emergency measure.\textsuperscript{188} North Carolina’s Emergency Medicaid Manual states (in its section addressing coverage for undocumented immigrants) that “once it is determined that the individual is eligible for hemodialysis, the medical review staff issues a blanket approval [that] [t]he individual meets the emergency service’s criteria for each hemodialysis treatment. The approval of emergency services for hemodialysis is indefinite.”\textsuperscript{189} This addition was made to the manual in 2011.

\begin{footnotes}
\footnotetext[184]{Weiner\textit{ supra} note 181, at 7.}
\footnotetext[186]{Id.}
\footnotetext[187]{Id.}
\footnotetext[189]{Id.}
\end{footnotes}
F. TEXAS

Texas has a large undocumented immigrant population, does not recognize PRUCOL status, and has declined Medicaid expansion.\textsuperscript{190} As a result, cities have “devised unique solutions” to remedy the issue.\textsuperscript{191} In San Antonio, county taxes fund scheduled dialysis through a contract with private, for-profit dialysis clinics.\textsuperscript{192} In Houston, patients initially receive emergent dialysis, but the county funds and operates a dialysis center that accepts patients based on capacity.\textsuperscript{193} In Dallas, only emergent dialysis is available.\textsuperscript{194} A study conducted by Texas nephrologists estimates that over one thousand undocumented immigrants residing in Texas need dialysis.\textsuperscript{195} The research indicates that “given the high cost of dialysis and the even higher cost of emergent dialysis, Texas taxpayers are likely paying more than $10 million to manage these patients.”\textsuperscript{196} The study also discusses the ethical dilemmas that physicians face every day, such as deciding which patients qualify for treatment.\textsuperscript{197}

G. Washington

The state of Washington specifically provides dialysis coverage for undocumented immigrants.\textsuperscript{198} Washington adopted the Affordable Care Act’s Medicaid expansion in January of

\textsuperscript{190} Kuruvilla and Garghavan, supra note 15.

\textsuperscript{191} Id.

\textsuperscript{192} Id.

\textsuperscript{193} Id.

\textsuperscript{194} Id.

\textsuperscript{195} Id.

\textsuperscript{196} Kuruvilla and Garghavan, supra note 15.

\textsuperscript{197} Id.

\textsuperscript{198} See generally, WAC 182-507.
2014. As a result, Washington’s Medicaid statute offers coverage for undocumented immigrants who meet all the state’s eligibility requirements, except for their citizenship status. The statute provides three forms of coverage for those who meet the aforementioned criteria. The first is Alien Emergency Medicaid, which pertains to “services necessary to treat an emergency condition that are provided in a hospital setting.” The second, Alien Medicaid for Dialysis and Cancer Treatment, explicitly covers dialysis and cancer treatment. The third covers state funded long term care. To qualify under the statute, the person must also meet the eligibility requirements for social security benefits generally, including financial eligibility and residency. The Washington statute specifically provides for coverage in the case of dialysis, and the Washington emergency Medicaid authority considers "[d]ialysis to treat acute renal failure or end stage renal disease (ESRD)" as an emergency medical condition and includes dialysis as a covered service. Coverage for dialysis treatment begins the day the person starts dialysis treatment, but not for any services before. The treatment also does not have to be performed in a hospital.

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200 Id.

201 Id.

202 Id.; See also WAC 182-507-0115

203 WAC 182-507-0110; WAC 182-507-0120.

204 WAC 182-507-0110; 182-507-0125.

205 Id.

206 WAC 182-507-0120.

207 Id.

208 Washington State Health Care Authority, Eligibility Overview, April 2015 at 7.
G. HHS’s Position on States’ Use of Emergency Medicaid for Dialysis

HHS does not appear to indicate any opposition to states' use of emergency Medicaid for outpatient dialysis. Pursuant to a CMS and HHA billing clarification statement, Medicare does not permit payment for routine dialysis furnished to ESRD patients in the outpatient department of a hospital.\(^{209}\) However, in situations where ESRD patients cannot obtain regularly scheduled dialysis at an outpatient facility, Medicare permits payment for non-routine treatments in a hospital's outpatient department.\(^{210}\) Such payment is allowed for "Emergency dialysis for ESRD patients who would otherwise have to be admitted as inpatients in order for the hospital to receive payment."\(^{211}\)

IV. How Indiana Can Resolve this Crisis

Indiana's present method of solely offering emergent, nonscheduled dialysis to undocumented ESRD patients is unnecessarily expensive and needlessly provides patients with lower quality care. As noted above, several states and communities have succeeded in providing standard dialysis (usually three times a week) in an outpatient setting. They have significantly minimized their expenditures by reducing prolonged hospital stays and frequent emergency room visits. Additionally, the quality of care is much higher in these states. As a result, not only is the ESRD patients’ suffering reduced, but they are also able to contribute to society. Most undocumented ESRD patients are employed, although many lose their jobs due to the irregular schedule associated with emergent dialysis. Patients who receive scheduled outpatient dialysis are able to work, as evidenced by B’s and S’s situations prior to the policy change.


\(^{210}\) Id.

\(^{211}\) Id.
Since no present initiative exists to return these patients to their home countries, nor do they plan to return to them, Indiana’s solution must focus on improving their access to dialysis while reducing the cost of care. Therefore, with proper treatment, undocumented ESRD patients can enjoy a higher quality of life while contributing to society by working and paying taxes. Indiana can follow the aforementioned states in the following manners.

**A. LEGISLATIVE SOLUTION**

One potential remedy is legislation to amend Indiana’s Code regarding its state Medicaid plan. Senator Jean Breaux, in partnership with physician advocates, introduced Senate Bill No. 276 in the January 2016 legislative session. The bill “would require the Family and Social Services Administration (FSSA) to apply for a Medicaid waiver or state plan amendment” to provide dialysis for undocumented ESRD patients. As a result, patients would receive ongoing scheduled outpatient dialysis rather than emergent dialysis in an emergency room setting.

A fiscal report was conducted, and concluded that scheduled dialysis treatment “may be fiscally neutral or result in an indeterminate level of cost savings to the Medicaid program through decreased utilization of emergency department services and inpatient admissions.” The report determined that Medicaid reimbursement for dialysis would benefit hospitals by decreasing uncompensated care, which would result in the patients’ improved health and ability to work. The fiscal analysis also acknowledged the financial perils of Indiana’s current policy, identifying that “patients must access services through the emergency department, incurring a facility fee as well as

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213 Id.
214 Id.
215 Id.
multiple physician fees;” “These patients may need to be admitted . . . to the intensive care unit to stabilize their conditions;” and “not continuing chronic care that is necessary leav[es] hospitals and other providers to assume the uncompensated care.” The report contrasts these findings with the cost of scheduled outpatient dialysis, referencing the widely cited statistic that emergent dialysis is 3.7 times more expensive.

B. ADMINISTRATIVE SOLUTION

Another solution involves the FSSA’s adoption of a broad interpretation of the federal definition of “emergency medical condition.” This mirrors the approach of states such as North Carolina and California, where the ability to provide scheduled outpatient dialysis is based on the breadth of the state’s interpretation of the statute. Such an interpretation would authorize Medicaid coverage for scheduled dialysis outside of an emergency room setting. Indiana code and North Carolina code define “emergency medical condition” in a nearly identical manner. Under Indiana code, an “emergency medical condition” is:

“medical condition that was manifested by symptoms of sufficient severity that the absence of immediate medical attention would probably result in any of the following: (1) Placing the individual’s life in jeopardy. (2) Serious impairment to bodily functions. (3) Serious dysfunction of any bodily organ or part.”

North Carolina perceives its definition of “emergency medical condition” to cover outpatient dialysis, and Indiana’s FSSA could similarly interpret this definition for the same purpose. A broad interpretation of “emergency medical condition” would be a “policy decision about addressing the
costs and human element of emergent dialysis,“\textsuperscript{219} without needing to undergo a lengthy legislative process.

\textbf{C. KIDNEY TRANSPLANT}

Although regular dialysis is a significantly more humane option than emergent dialysis and yields better health outcomes at a lower cost, the ultimate solution to the issue of undocumented immigrants with end-stage renal disease is kidney transplantation.\textsuperscript{220} In regard to quality of life, lifespan, and cost, kidney transplantation is a far better treatment than dialysis.\textsuperscript{221} The fact that most undocumented immigrants with end-stage renal disease are young and have few comorbid conditions makes them excellent candidates for successful transplants.\textsuperscript{222} Those factors coupled with their widespread eagerness to work makes them likely to continue working or re-enter the workforce.\textsuperscript{223}

Law and public policy is largely silent on the issue of kidney transplants for undocumented immigrants.\textsuperscript{224} Eligibility to enlist for a transplant is left to the discretion of individual transplant centers, but even if undocumented immigrants were allowed to enroll by all transplant centers, their lack of access to insurance that would typically cover the costs of transplants effectively precludes them from these programs.\textsuperscript{225}

\begin{flushleft}
\textsuperscript{219} Rodríguez, supra note 169.
\textsuperscript{221} Id.
\textsuperscript{222} Id.
\textsuperscript{223} Id.
\textsuperscript{224} Id.
\textsuperscript{225} Id.
\end{flushleft}
From a financial standpoint, it is certainly more cost effective to implement a policy of kidney transplants than emergent or even regular dialysis. Medicare spends about $110,000 for one kidney transplant and a year of follow-up care, which would be recovered in fewer than 18 months. After the first year of follow-up care, Medicare spends $27,000 on a transplant recipient whereas an individual who remains on dialysis costs $77,000 per year.

Kidney transplants for undocumented immigrants is not without its challenges. There is currently a shortage of deceased donor organs and the waiting list for kidney transplants contains almost 90,000 Americans. However, authors of a study in the American Journal of Kidney Diseases reported that 93% of their 27 patients said they already have potential living donors, most of whom reside relatively close by in the United States, Canada, or Puerto Rico. In addition, the potential donors are young, healthy, and are mostly relatives of the patients. A study conducted at the University of Illinois estimated that half of the state's undocumented immigrants in need of kidney transplants already have living donors and would not affect the organ pool for legal residents and citizens.

A model to look to for kidney transplant policies was recently implemented in Illinois. In October 2014, a provision in the state's 2014 Medicaid law paved the way for kidney transplants for undocumented immigrants.

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226 Linden et al., supra note 220.
227 Id.
228 Id.
229 Id.
230 Id.
231 Id.
232 Id.
undocumented immigrants went into effect.\textsuperscript{234} Transplant centers in Illinois now evaluate whether candidates are healthy enough to receive kidney transplants and place some of them on waiting lists.\textsuperscript{235} In order to ensure the transplants will be effective, candidates must show that they have $80,000 in their bank account to cover a few years of anti-rejection medication that is needed to keep the kidney functioning for several years.\textsuperscript{236} Illinois will pay hospitals and physicians between $60,000 to $70,000 per transplant, which is the same rate it pays for citizens enrolled in Medicaid.\textsuperscript{237} The difference in the state's payments for transplants for citizens and undocumented immigrants is that it would pay one lump sum of $15,000 for undocumented transplant recipients' ancillary services, including tests, provider fees, and donor costs.\textsuperscript{238} If any complications or need for additional treatment arises, hospitals will not get reimbursed, but some administrative officials at academic medical centers in Chicago are working with legislators to devise solutions to expand access to anti-rejection medications and health insurance.\textsuperscript{239}

VI. Conclusion

Due to a severe restriction on their access to treatment, undocumented patients with ESRD in Indiana are facing a crisis. Throughout Indiana, these patients’ sole recourse is to present to the emergency room at the brink of death and receive dialysis pursuant to EMTALA. This method not only endangers the patients’ lives on a regular basis, but also drains hospitals of their funds. Since EMTALA prevents hospitals from turning these patients away and legally requires them to provide

\textsuperscript{234} Id.
\textsuperscript{235} Id.
\textsuperscript{236} Id.
\textsuperscript{237} Id.
\textsuperscript{238} Id.
\textsuperscript{239} Rodriguez, supra note 233.
care, this can be done in an expensive manner or in a fashion that curbs the enormous expenses that can arise. Indiana must follow the example of various states and adopt solutions that avoid condemning undocumented ESRD patients to inadequate and costly emergent dialysis care. Indiana should qualify ESRD as an “emergency medical condition” pursuant to EMTALA, triggering Medicaid coverage for outpatient dialysis. As outlined above, this solution can be implemented legislatively, judicially, or administratively.