SB 627 - Medicaid Emergency Dialysis - Letter of S
Uploaded by: Erin Dorrien
Position: FAV

Maryland
Hospital Association

March 14, 2023

To: The Honorable Melony G. Griffith, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 627- Maryland Medical Assistance Program - Emergency Dialysis Services

Dear Chair Griffith:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 627. MHA supports updating emergency Medicaid to include scheduled outpatient dialysis for undocumented immigrants as it would improve health outcomes and promote health equity as well as ease feelings of professional burnout.

There are approximately 6,500 undocumented immigrants with end-stage renal disease in the United States.[1] Since their undocumented status renders them ineligible for Medicaid and unable to purchase qualified health plans through the Maryland Health Benefit Exchange, for many undocumented immigrants their only source of dialysis is the hospital emergency department. Emergency dialysis, however, is a poor substitute for scheduled outpatient dialysis. Compared with standard dialysis, emergency-only dialysis has a 14-times higher mortality rate.[2]

Undocumented immigrants receiving emergency-only dialysis also experience more physical pain, have a lower level of physical function, and suffer severe physical symptoms and mental suffering.[3] Scheduled outpatient dialysis would improve this group's health outcomes and quality of life.

Enabling Medicaid outpatient dialysis for undocumented immigrants would also promote health equity. The undocumented immigrant population tends to be Latino, younger, and less educated when compared to the documented Latino immigrant community.[4] This group also potentially has heightened morbidity and mortality risks if infected with COVID-19.[5] Expanding emergency Medicaid coverage to include standard dialysis would help remove the disproportionate burden on this vulnerable population.

Finally, providing access to routine outpatient dialysis would help improve workforce morale. A study of clinicians experienced in providing emergency-only dialysis in a safety-net hospital

[1] "Not Yet Sick Enough to Qualify for Care," AMA Journal of Ethics, February 2021. journalofethics.ama-assn.org/article/not-yet-sick-enough-qualify-care/2021-02
[2] "Hemodialysis Care for Undocumented Immigrants with ESRD in the United States," National Library of Medicine, November 2019. ncbi.nlm.nih.gov/pmc/articles/PMC9352150/
[3] ibid
[4] "Dialysis Care for Undocumented Immigrants With Kidney Failure in the COVID-19 Era: Public Health Implications and Policy Recommendations," National Library of Medicine, August 2020. ncbi.nlm.nih.gov/pmc/articles/PMC7217077/
[5] ibid

found that the providers suffered signs of burnout.[6] Providers were distressed that patients were unable to access the available routine dialysis care they need.[7] Maryland continues to experience health care workforce shortages, and preventing or reducing burnout helps maintain a robust health care workforce.

Maryland hospitals and MHA began raising access concerns for dialysis patients who rely on emergency departments in late 2019. At that time, MHA, hospital social workers teams, and the Department of Health presented to the Maryland Commission on Kidney Disease on the need to ensure greater access to outpatient dialysis for special populations, including undocumented immigrants. Work on these issues was beginning when the COVID-19 pandemic started. This legislation would create a sustainable solution for a population to get the care they need in the most appropriate setting.

For these reasons, we request a ***favorable*** report on SB 627.

For more information, please contact:
Erin Dorrien, Vice President, Policy
Edorrien@mhaonline.org

[6] "Getting dialysis for undocumented patients,"' 'ACP Internist, February 2021. acpinternist.org/archives/2021/02/getting-dialysis-for-undocumented-patients.htm
[7] ibid

SB0627-FIN-FAV.pdf
Uploaded by: Nina Themelis
Position: FAV

BRANDON M. SCOTT
MAYOR

Office of Government Relations
88 State Circle
Annapolis, Maryland 21401

SB0627

March 14, 2023

TO: Members of the Senate Finance Committee

FROM: Nina Themelis, Interim Director of Mayor's Office of Government Relations

RE: Senate Bill 627 – Maryland Medical Assistance Program - Emergency Dialysis Services

POSITION: Support

Chair Griffith, Vice Chair Klausmeier, and Members of the Committee, please be advised that the Baltimore City Administration (BCA) **supports** Senate Bill (SB) 627.

SB 627 requires the Maryland Medical Assistance Program to provide coverage for dialysis services to certain noncitizen individuals with end-stage kidney disease (ESKD) to receive dialysis at least three times per week. These individuals would otherwise be eligible for dialysis treatments covered by the Maryland Medical Assistance Program if not for their immigration status. Failure to receive dialysis when needed by persons with end-stage renal disease can lead to severe health complications, disabilities, and death.

There currently is no cure for ESKD. Patients with severe kidney disease are typically treated with routine dialysis or kidney transplants. Medicare covers the cost of dialysis for most US citizens who require these treatments. Non-citizens are eligible to donate organs, but nationally are excluded from most government coverage programs and are often not eligible to be organ recipients.[1] Patients who lack access to routine dialysis are almost five times more likely to die (when receiving emergency-only dialysis), have higher rates of emergency room visits, more hospital admissions, and spend more days in the hospital during those admissions.[2]

For these reasons, the BCA respectfully requests a **favorable** report on SB 627. Providing routine dialysis for Maryland's non-citizens with ESKD can result in cost savings for our hospital systems and alleviate care burden within emergency departments. Routine dialysis is also equitable ethical healthcare for ESKD non-citizens who require this life-saving care.

[1] End Stage Kidney Disease in Non-citizen Patients: Epidemiology, Treatment, and an Update to Policy in Illinois | SpringerLink
[2] Improving dialysis for undocumented immigrants with ESRD (umich.edu)

SB 627- LWVMD- FAV- Maryland Medical Assistance Pr

Uploaded by: Nora Miller Smith

Position: FAV

LEAGUE OF WOMEN VOTERS® OF MARYLAND

TESTIMONY TO THE SENATE FINANCE COMMITTEE

SB 627: Maryland Medical Assistance Program- Emergency Dialysis Services

POSITION: Support

BY: Nancy Soreng, President

DATE: March 14, 2023

The League of Women Voters Maryland supports **Senate Bill 627: Maryland Medical Assistance Program- Emergency Dialysis Services,** which would classify End-Stage Renal Disease (ESRD) as an emergency medical condition. This change would enable dialysis-dependent undocumented individuals to receive standard outpatient dialysis care, instead of being forced to rely on intermittent "emergency-only" dialysis in hospital Emergency Departments, paid for by emergency Medicaid funds.

ESRD is the final, permanent stage of chronic kidney disease. It is a fatal condition, and dialysis is life support. When a patient's kidneys are no longer functioning, only ongoing dialysis or kidney transplantation will keep that patient alive.

Because undocumented immigrants in Maryland with ESRD are ineligible for Medicare, Medicaid, or coverage through the Health Benefit Exchange, at present they can only receive dialysis under EMTALA regulations when they are taken to hospital EDs in critical condition.

Patients who rely on this emergency-only weekly dialysis describe recurrent near-death experiences that terrify them and their families. Without functioning kidneys, patients can gain fifteen pounds of extra fluid weight in a week, which accumulates in their limbs, face, lungs and heart. They feel like they're drowning. Toxins and excessive salts in their blood can lead to fatal heart arrythmias. If they are able to reach a hospital ED, they're admitted to the ICU and given back-to-back dialysis sessions over two days. Some don't reach the ED, and die at home, or en route, from cardiac arrest.

Patients receiving emergency-only hemodialysis are 14 times more likely to die than those receiving standard dialysis.[1] These are desperately ill patients. As one physician said: "People…can die within two seconds because they go into an arrythmia."[2] Clinicians experience emotional exhaustion and burnout, knowing that because of a legal technicality they are repeatedly delivering substandard care.

Hilda was an undocumented immigrant in her early thirties who lived in Colorado with her two young sons. She had ESRD, but because of her documentation status was forced to rely on intermittent, emergency-only dialysis. She suffered three cardiac arrests, witnessed by her children, who called 911 each time. After deciding she could no longer subject her children to that constant level of fear and trauma, Hilda found a loving family to adopt them. She then stopped going to the ER, accepted palliative care, and died.

[1] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2665387
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9352150/

After her death, Hilda's medical providers went to the Colorado state legislature to try to protect other patients. Five years later, ESRD was added to Colorado's list of emergency medical conditions, thus enabling the state's 90 undocumented immigrants with ESRD to receive scheduled outpatient dialysis.

This change was not only humane, it made fiscal sense. By covering outpatient dialysis for those 90 patients, **Colorado's emergency Medicaid program saved $1.6 million per month[3], or $19.2 million per year.** Studies in other states have shown that costs for emergency-only dialysis **"can be as high as $400,000 per person per year, more than four times the $90,971 that Medicare spends per patient per year on hemodialysis patients**."[4]

Emergency-only hemodialysis is costly for Maryland hospitals, which are penalized for readmissions, and is a great burden on their ED's and ICU's.

And it is also very costly for the State of Maryland and its taxpayers. If we extrapolate from Colorado's numbers (190,000 undocumented individuals, 90 of which have ESRD), we can estimate that of Maryland's 275,000 undocumented population, perhaps 130 of them have ESRD. Based on Colorado's experience of saving $19.2 million per year by switching 90 patients from emergency-only to standard hemodialysis, **we can estimate that Maryland could save $27.7 million per year by doing the same with our patients.**

"**It is clear that states who are providing emergency-only rather than standard dialysis to undocumented immigrants are providing less efficient care with worse clinical outcomes, all at a much higher cost." [5]**

Twelve states[6] (CA, WA, AZ, CO. MN, WI, IL, NC, VA, PA, NY, MA) and Washington D.C. **have changed the scope of their Emergency Medicaid coverage to include outpatient dialysis**. CMS defers to states to determine which conditions qualify as emergencies, and those emergencies don't have to be treated in an inpatient setting.

Three of those states (PA, VA, and NC) are Maryland's neighbors, and have comparable undocumented populations (170,000-325,000) to Maryland (275,000). And **"evidence from California suggests that…allowing coverage for scheduled hemodialysis does not lead to an influx of undocumented patients needing dialysis."[7]**

Adding ESRD to the list of emergency medical conditions covered by emergency Medicaid would enable the small numbers of undocumented immigrants in Maryland with ESRD to receive standard outpatient dialysis, rather than being forced to rely on emergency treatment when they are on the brink of death. While this change would affect a relatively small number of Maryland residents, it would save our state Medicaid system millions of dollars per year. This is humane, fiscally responsible policy.

One physician noted: "I don't think [legislators] understand how tragic it is. I don't think they understand how easy it would be to fix."[8]

The League and its over 1,500+ members urge a favorable report on Senate Bill 627.

---

[3] https://centerforhealthprogress.org/blog/changing-dialysis-policy-saved-lives-and-money/
[4] https://www.kidney.org/sites/default/files/support_letter_for_dialysis_for_undocumented_people_20210929.pdf
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9352150/
[6] https://www.kidney.org/sites/default/files/support_letter_for_dialysis_for_undocumented_people_20210929.pdf
[7] https://www.asn-online.org/publications/kidneynews/archives/2021/KN_2021_09_sep.pdf
[8] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9352150/

SB_627_Emergency Dialysis Testimony.pdf
Uploaded by: Olivia Farrow
Position: FAV

Ascension
Saint Agnes
Hospital

March 13, 2023

To: The Honorable Melony G. Griffith, Chair, Senate Finance Committee

Re: Letter of Support- Senate Bill 627- Maryland Medical Assistance Program - Emergency Dialysis Services

Dear Chair Griffith:

On behalf of Ascension Saint Agnes Hospital (ASA), in Baltimore, Maryland, we appreciate the opportunity to comment in **support of Senate Bill 627**. The Bill requires the Maryland Medical Assistance Program to provide coverage for dialysis services to noncitizens under certain circumstances. Ascension Saint Agnes supports coverage of outpatient dialysis for noncitizen immigrants under the Maryland Medical Assistance Program as we have seen many patients who would greatly benefit from regular and consistent care that would improve their overall health outcomes.

The Ascension Saint Agnes mission states "...we commit ourselves to serving all persons with special attention to those who are poor and vulnerable." Because of this mission, we serve those noncitizen immigrants who reach our Emergency Department (ED) in dire need of dialysis services. These patients are unable to seek routine services at local dialysis centers due to their lack of insurance coverage. These patients coming to the ED routinely require and receive *three-times-weekly* dialysis treatment. These patients should be receiving a level of care that includes a sustainable plan for ongoing dialysis in an environment that supports their continuing needs.

Emergency dialysis is a poor substitute for scheduled outpatient dialysis. From the patients' standpoint, it is unsafe as these patients at discharge are provided instructions on symptoms that should trigger a visit to the ED for urgent dialysis. This is a poor way to manage the patient as it puts them at greater risk for morbidity and mortality since, for example, "hyperkalemia," which can lead to life-threatening heart arrhythmias, may not have any symptoms at all until it causes harm. Discharging patients without a sustainable safe plan for ongoing dialysis services places unnecessary stress on physicians and discharge planners that have a primary duty to ensure a safe discharge. Scheduled outpatient dialysis would improve this group's health outcomes and quality of life.

Emergency dialysis is a really poor use of our healthcare resources as these patients cycle through our EDs for what should be routine outpatient dialysis. One example is that of a young 51 year old man who has been visiting our ED for dialysis since July 2021 with a total of 245 visits for dialysis as of the writing of this testimony. With a cost of $415 per treatment, the total cost in 2022 for all of our patients seeking this care was about $210,000 for the year. And in our attempt to ensure ongoing care for those most in need, we incurred an additional $130,000 for that year for contracts with community providers. Under the fiscal environment that we and other hospitals are coping with in the past few years, the financial burden of ED dialysis weighs heavily as we attempt to turn the corner on not only our financial health but also our workforce crisis.

Providing access to routine outpatient dialysis would help improve workforce morale. A study of clinicians experienced in providing emergency-only dialysis in a safety-net hospital found that the providers suffered signs of burnout.[1] Providers were distressed that patients were unable to access the available routine dialysis care they need.[2] Maryland continues to experience health care workforce shortages, and preventing or reducing burnout helps maintain a robust health care workforce.

It is important to finally note that this particular issue has been a growing concern since 2019. Continued financial support of emergency dialysis, for those who require routine dialysis, is an unsustainable model and in the end diverts hospital charity dollars from supporting patients who can only receive support in the hospital and not in the community. Routine care that can be achieved in the community serves the patient and our healthcare system best.

For these reasons, we request a ***favorable*** report on Senate Bill 627.

For more information, please contact:
Olivia D. Farrow, Director of Community Engagement & Advocacy
Ascension Saint Agnes Hospital
Olivia.Farrow@Ascension.org

[1] "Getting dialysis for undocumented patients,"' 'ACP Internist, February 2021. acpinternist.org/archives/2021/02/getting-dialysis-for-undocumented-patients.htm
[2] ibid

5 - SB 627 - FIN - MA - LOSWA.docx.pdf
Uploaded by: State of Maryland (MD)
Position: FWA

Maryland
DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

March 14, 2023

The Honorable Melony Griffith
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

RE: SB 627 – Maryland Medical Assistance Program – Emergency Dialysis Services – Letter of Support with Amendments

Dear Chair Griffith and Committee Members:

The Maryland Department of Health (MDH) respectfully submits this letter of support with amendments for Senate Bill (SB) 627 – Maryland Medical Assistance Program – Emergency Dialysis Services. SB 627 requires Maryland Medicaid to provide coverage for dialysis services to non-citizen individuals with End-Stage Renal Disease (ESRD), who would be eligible for Medicaid but for their immigration status, beginning January 1, 2025.

Dialysis is a critical, life-sustaining service when needed. Maryland Medicaid currently already provides coverage for dialysis services to non-citizen individuals with End-Stage Renal Disease (ESRD), who would be eligible for Medicaid but for their immigration status. Specifically, Emergency Medical Services are provided for non-qualified or undocumented non-citizens who would otherwise meet financial eligibility for Medicaid as stated in Hospital Transmittal No. 277.[1] Maryland Medicaid provides coverage for both emergency medical services provided in the hospital (COMAR 10.09.24.05-2) and dialysis at freestanding facilities. Dialysis is a covered benefit when prescribed by a Maryland Medicaid Provider and approved by Maryland Medicaid (or through its designee).[2] Approval is up to 12 months, with 12-month renewable certification periods (unlike other Emergency Medical Services, which require certification each time they are received). The frequency of weekly dialysis service and length of dialysis treatment are determined by the Provider and based on the degree of End-Stage Renal Disease (ESRD). Medicaid is in the process of updating its website and releasing clarifying guidance to providers regarding coverage for dialysis services allowed under this existing policy.

MDH's interpretation of our guidelines is that the guidelines go further than the coverage required in the bill. However, because circumstances change and treatments and medical standards of care evolve, MDH recommends language that would give MDH flexibility in the future. Our recommended amendments are below.

[1] Hospital Transmittal No. 277
[2] COMAR 10.09.24.05-2

If you need more information, please contact Megan Peters, Acting Director of Governmental Affairs, at megan.peters@maryland.gov or (410) 844-2318.

Sincerely,

Laura Herrera Scott, M.D., M.P.H.
Secretary

MDH Amendments to Senate Bill 627

On page 2, in line 18, after "2025" insert "**SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET**".

On page 2, strike beginning with "**WHEN**" in line 21 down through "**ORGAN**" in line 28 and substitute "**IN ACCORDANCE WITH MEDICAL GUIDELINES DEVELOPED BY THE PROGRAM**".