April 27, 2021

By E-mail Only

Governor Ned Lamont
State Capitol
210 Capitol Avenue
Hartford, CT 06106

Commissioner Deidre S. Gifford
Department of Social Services
55 Farmington Avenue
Hartford, CT 06105

Re: Request for Reversal of the Department of Social Services' Policy Denying Life-Sustaining Dialysis Treatment for End-Stage Renal Disease as an Emergency Medical Condition under Medicaid

Dear Governor Lamont and Commissioner Gifford:

We are writing to urge you to revise the state's current emergency medical condition (EMC) Medicaid position which denies coverage for life-sustaining outpatient renal dialysis services for undocumented individuals with end stage renal disease (ESRD). Right now, a client of New Haven Legal Assistance Association is in-patient at the hospital in order to receive essential dialysis services to stay alive, as a request for payment for outpatient dialysis was denied. We write immediately on behalf of this client, but we have been told of several other recent cases in which DSS has denied coverage for outpatient dialysis, putting patients in various Connecticut hospitals in an untenable position. We urge immediate relief for this individual and a reversal of the department's policy generally.

As explained in greater detail below, because (1) outpatient dialysis meets the federal regulatory definition of an EMC, (2) federal reimbursement is available for providing these services, (3) an increasing number of states have developed formal guidance for providing indefinite Medicaid payment for outpatient dialysis as an EMC, including a growing number of our neighboring states, (4)the failure to cover this on an outpatient basis means much higher Emergency Department (ED) and in-patient hospital expenses, as illustrated in the case of this client, and (5) basic morality urges governmental action in this matter of life and death, we urge you to join the other states in formalizing a policy which covers outpatient dialysis indefinitely as an EMC where medically necessary. We urge you to begin by immediately allowing payment for this service for Ms. R., the client who is currently in-patient referenced above.

Facts of Ms. R. Confined to Hospital in Order to be Kept Alive, Based on DSS Denial

Ms. R. (full name provided in attached statement) has been in-patient at Yale New Haven Hospital (YNHH) since December 8, 2020. At that time, she was admitted following an ED visit necessitated by rapidly declining health due to ESRD symptomatology. She was placed on dialysis; without this treatment, she would have died in a few days. She continues to require dialysis to survive: as explained by her treating doctor in a letter dated March 15, 2021 addressed to the Department's medical review contractor, Community Health Network of Connecticut (CHNCT), "[w]ithout regular dialysis, three times per week, she would die, somewhere between one and two weeks from the time of discharge without dialysis." Because her outpatient dialysis is not covered, she would go without this critical care if she were not inpatient and her health would then decline until she returned to the ED, where she would then be admitted in-patient. This care is covered as an EMC under the Department's current standards, as would be her repeated arrivals in the hospital ED, followed by stabilization through dialysis treatment and discharge, until a few days later when severe symptomatology would return and the dangerous and expensive cycle would repeat itself.

Nevertheless, upon receipt of a formal request for prior authorization for Medicaid payment for the outpatient dialysis essential to keep her alive, dated March 18, 2021 and submitted by her treating provider, CHNCT summarily denied the request on the stated basis that "we are unable to process your request at this time. Member's current eligibility shows not eligible on the requested date of service." Obviously, Ms. R. is not eligible for Medicaid generally because of her immigration status. That is precisely why her provider's request was for prior authorization and a determination of eligibility specifically for **EMC Medicaid** based on her urgent need for dialysis due to her ESRD, which is in fact an EMC. It is this status which makes her eligible for this kind of limited Medicaid coverage. But DSS's contractor, apparently acting under DSS's instructions, refused to even consider whether she has an EMC, declaring it would not consider her request for this kind of eligibility for Medicaid for the circular reason that she was not already eligible for Medicaid. (The Department also failed to comply with federal due process requirements, 42 C.F.R. § 431.206, which required it or CHNCT to send a written notice to Ms. R. advising of the decision and her right to appeal.)

Outpatient Dialysis to Keep People with ESRD Alive Meets Federal EMC Definition

Second, ESRD treatment in the form of renal dialysis, for someone like Ms. R. who first appears in the ER due to sudden acute symptoms and who, without this treatment, will not just suffer severe impairment of bodily functions but **death within a few days to two weeks**, readily meets the EMC standards of federal Medicaid regulations. Those regulations provide:

> "[A]liens who are not lawfully admitted for permanent residence in the United States or permanently residing in the United States under the color of law must receive the services necessary to treat the condition defined in paragraph (1) of this section if -
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> **(1)** The alien has, after sudden onset, 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:

(i) Placing the patient's health in serious jeopardy;

(ii) Serious impairment to bodily functions; or

(iii) Serious dysfunction of any bodily organ or part"

42 C.F.R. § 440.255(c).

Although some court cases have suggested that dialysis does not meet these EMC standards, *see Quiceno v. DSS*, 45 Conn. Supp. 580, 728 A. 2d 553 (Conn. Super. Ct 1999), others, including cases in Connecticut, indicate the standards are readily met, *see Gaddam v. Rowe*, 44 Conn. Supp. 268, 684 A.2d 286 (Conn. Super. Ct 1995); *Padilla v. Biedess*, No. CIV 02-176-TUC-WOB (D. Ariz. Sept. 25, 2002)(preliminary injunction), *see also Szewczyk v. DSS*, 881 A.2d 259 (Conn. 2005)(chemotherapy treatment for leukemia is an emergency medical condition).

Increasing Numbers of States, Including Those Surrounding CT, Paying for Outpatient Dialysis

Third, at least fourteen, and possibly more, states are already paying for outpatient dialysis as EMC treatment. Many states have developed formal written policies which expressly provide coverage for this as an EMC on an indefinite basis (since kidney transplants, the only alternative means of keeping someone with ESRD alive, are categorically excluded as an EMC under federal Medicaid statutes and regulations). For example, North Carolina's Integrated Eligibility Manual provides, in Section 15190 (Coverage for Emergency Medical Services):

> Once it is determined that the individual is eligible for hemodialysis, the medical review staff issues a blanket approval by stating …"all on going hemodialysis…" * * * For future applications for this individual, do not submit medical information for hemodialysis. The individual meets the emergency service's criteria for each hemodialysis treatment. *The approval of emergency services for hemodialysis is indefinite*. (emphasis added).

https://economicbenefits.nc.gov/FN_A/FN_A/server/general/projects/Integrated%20Eligibility%20Manual/Program_Specific_Policy/15000_Medicaid/15100_Alien_Requirements/MA_3330_X_Coverage_for_Emergency_Medical_Services.htm

Similarly, in Colorado:

> Effective February 1, 2021, the [Colorado] Department of Health Care Policy & Financing will consider End-Stage Renal Disease (ESRD) an emergency medical condition. An emergency medical condition is one that places a patient's health in serious jeopardy, could result in serious impairment to bodily functions, or could cause serious dysfunction of any bodily organ or part.
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> **Where can these patients receive services?**
> Recipients of Emergency Medicaid, who have a diagnosis of ESRD, can access services necessary for the treatment of the disease in either the inpatient setting—as they have previously—or at an independent, free-standing dialysis center.

https://www.colorado.gov/pacific/sites/default/files/ESRD%20Emergency%20Medicaid%20FAQ%20Updated%201-31-19.pdf

Some of these state positions also are long-standing *See, e.g.* https://www.dhs.state.il.us/page.aspx?item=19608 (Illinois Department of Human Services recognizes since 2003 that, under Medicaid, "ESRD is considered an emergency medical condition"); http://www.dpw.state.pa.us/oimpolicymanuals/manuals/bop/ops/ops-04-03-01.htm (PA Medicaid policy in effect since 2004).

Some states also have formally changed their official regulatory definition of EMCs to expressly cover dialysis for ESRD. *E.g.,* Arizona Admin. Code R9-22-217; Fla. Admin. Code R. 59G-1.058. At least one state, Minnesota, covers this by statute: 256B.06 ELIGIBILITY; MIGRANT WORKERS; CITIZENSHIP (available at https://www.revisor.mn.gov/statutes/cite/256B.06)**.**

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Here are just a few of the other states' guidance to this effect:

DC: Memo (September 2013 Transmittal No. 13-15.adding dialysis EMC coverage effective in Fiscal Year 2014)

Maryland: Medicaid manual (page 525)(in addition to hospital based services, "Emergency medical services may also include: … Dialysis and related services for end stage renal disease (ESRD)")

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Utah: instructions for providers (listing "clinical eligibility requirements for coverage of outpatient hemodialysis").

The growing number of states which provide renal dialysis for ESRD as an EMC include New York and Massachusetts, and a medical director for Rhode Island's Medicaid program has recently indicated approval of other states' such policies.

In August 2019, a comprehensive analysis of state policies published in the *Clinical Journal of the American Society of Nephrology* showed that 12 states and the District of Columbia reimbursed providers for outpatient dialysis as an EMC under Medicaid, while another 16 were found to have funds which cover standard outpatient dialysis albeit outside of Medicaid (which means available federal reimbursement is being foregone). "The Status of Provision of Standard Outpatient Dialysis for US Undocumented Immigrants with ESKD" (August 7, 2019), available at https://cjasn.asnjournals.org/content/14/8/1258 There is at least one state (Florida), however, which was identified in the article as not providing coverage for dialysis as an EMC that now clearly does. At a minimum, at least 14 states now formally cover dialysis as an EMC. (There may be other states that have also started covering outpatient dialysis as an EMC since August of 2019.)

Federal Medicaid Reimbursement Available for All Expenditures for Outpatient Dialysis

Fourth, since dialysis for ESRD so readily meets the standards set forth in 42 CFR § 440.255(c) that this coverage appears to be mandatory ("aliens …***must*** receive the services necessary to treat the condition defined in paragraph 1 of this section…")(emphasis added), federal reimbursement is readily available. This is confirmed by the fact that, even under the Trump Administration, which took a highly restrictive

view of public benefits for non-citizens, no states have been audited for receiving federal reimbursement for providing payment for this service as treatment for an EMC. As noted in the 2019 American Society of Nephrologists journal article, "The [HHS/CMS Office of the Inspector General] audits a state's compliance with its own state definition of an emergency medical condition and has not previously raised concerns in states where dialysis for undocumented immigrants is covered." (https://cjasn.asnjournals.org/content/14/8/1258) For example, in Washington State, where undocumented immigrants with kidney failure receive scheduled dialysis that is reimbursed under Medicaid because the scope of services covered by Emergency Medicaid includes dialysis (Washington Administrative Code 182-507-0120; https://app.leg.wa.gov/WAC/default.aspx?cite=182-507-0120), Washington was audited by the OIG in 2010, and the coverage of scheduled dialysis was not questioned under the federal definition (OIG Report on Washington State's Medicaid Claims A-09-09-00039). *See* "Offering Better Standards of Dialysis Care for Immigrants" (October 2020), at https://cjasn.asnjournals.org/content/15/10/1516

While this coverage appears to be **required** under the governing definition of EMC in 42 C.F.R. §440.255(c), at a minimum. this indicates that federal reimbursement is readily available when a state chooses to provide coverage for this -- which means either 50% reimbursement under HUSKY A and C or 90% reimbursement under HUSKY D. In Ms. R's case, almost all of the cost of outpatient dialysis would be borne by the federal government because she qualifies for HUSKY D coverage at 90% match. Although ESRD is identified as a disability under Social Security Administration regulations, there is no reason individuals who suffer from ESRD must necessarily be covered by HUSKY C with its increased cost to the state, when they are, as in Ms. R's case, under 65, not on Medicare or pregnant, and within the income limits of HUSKY D.

Higher Cost to State if Outpatient Dialysis Not Provided

Fifth, paying only for emergency dialysis and **not** paying for outpatient dialysis means significantly higher outlays for the state under Medicaid, even in the short-run. As noted in the 2019 journal article:

> Emergency-only hemodialysis is expensive from a societal perspective, although to a hospital or health care system, it may be reimbursed by emergency Medicaid. * * *. A study of 32 patients previously receiving emergency only hemodialysis dialysis demonstrated a reduction in emergency room visits, days hospitalized, and transfusions after obtaining commercial health insurance and receiving routine thrice-weekly hemodialysis.

*See also "*Dialysis Care for Undocumented Immigrants With Kidney Failure in the COVID-19 Era: Public Health Implications and Policy Recommendations" (May 12, 2020)("emergency-only dialysis costs $285,000 to $400,000 per person per year, compared with $76,177 to $90,971 per person per year for standard dialysis")(available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7217077/)

The case of Ms. R. illustrates this point. As her doctor noted in his March 15, 2021 letter, ongoing outpatient dialysis treatment for her "will allow her to be discharged from the hospital, with her needed

care then provided at only a small fraction of the cost of her care in the hospital." Indeed, the total hospital bill for Ms. R. now exceeds a million dollars, most or all of which will be paid for by Medicaid as an EMC. Even if this bill is not entirely covered by DSS as an EMC, most of it will be, resulting in a cost to the state many times exceeding the relatively modest annual cost of paying for outpatient dialysis as an EMC. In Ms. R.'s case, her confinement to the hospital exposed her to the risks of contracting COVID-19, which she in fact contracted there, making her care substantially more complicated and expensive. While federal reimbursement is also available for this hospital-based care, since Connecticut has to pay a percentage, the much larger hospital bill means a much higher bill for the state as well, all made necessary due to DSS's failure to cover the state's share of the modest cost of outpatient dialysis for individuals in this situation.

Moral Obligation of State to Pay for this Life-Sustaining Treatment

Finally, we believe that the policies of state government should reflect the moral values of the state's people. In a study in three cities in different states, "the mean 5-year relative hazard of mortality for patients who rely on [hospital-based] emergency-only dialysis was >14-fold higher compared with those who receive standard hemodialysis." 2019 American Society of Nephrologists journal article (https://cjasn.asnjournals.org/content/14/8/1258) Additionally, "a retrospective study of undocumented immigrants with ESKD [end-stage kidney disease] who died after presenting to the hospital for emergency-only hemodialysis showed the majority had an electrical rhythm disturbance and died of cardiac arrest. Clinicians who provide emergency-only hemodialysis care report emotional exhaustion from witnessing needless suffering and high mortality as well as moral distress from the perception of propagating injustice." Ibid. None of this is surprising: "Increasing time between dialysis sessions increases the risk for fatal arrhythmias, hypoxia from volume overload, uremia, and complications when they finally receive dialysis." *See "*Dialysis Care for Undocumented Immigrants with Kidney Failure in the COVID-19 Era: Public Health Implications and Policy Recommendations," *American Journal of Kidney Disease* (May 12, 2020), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7217077/.

In *Gaddam v. Rowe*, the court, in requiring payment for dialysis as an EMC, would not allow "medical 'Russian roulette' that the state agency position requires, i.e. stop the [dialysis] payment, wait a short time for symptoms to recur, and then hope there is time to get the patient to the hospital to restart the treatment before the patient dies." 44 Conn. Supp. at 272. Allowing someone to die an agonizing death—or go through repeated rounds of severe, terrifying acute symptoms, followed by an ER visit, in-patient admittance and then stabilization and discharge, to be repeated again just days later—cannot be what Connecticut citizens expect of their government, especially when the surrounding states are already covering this under the same federal Medicaid rules and receiving substantial federal reimbursement for doing so.

Conclusion

There is a growing movement to cover undocumented individuals under HUSKY with entirely state funds. We in legal services support that proposal. Nevertheless, for all of the above reasons, we urge

you at the very least to formally adopt a new policy along the lines of Arizona, Florida, North Carolina, Colorado, Utah and numerous others states, expressly providing for ongoing outpatient dialysis coverage under Medicaid as an EMC for such individuals with ESRD, with federal reimbursement readily provided for all such expenditures.

We also urge you to immediately provide coverage for Ms. R. so that she may be released from the hospital, where she has effectively been imprisoned (for humanitarian reasons) for over four months largely at the taxpayers' expense, and return to her family.

Thank you for your consideration of this urgent request.

Respectfully,

Sheldon V. Toubman
Staff Attorney
New Haven Legal Assistance Association
stoubman@nhlegal.org

Alison Weir
Policy Advocate
Greater Hartford Legal Aid
aweir@ghla.org

Kristen Noelle Miller Hatcher
Manager, Benefits Unit
Connecticut Legal Services
KHatcher@connlegalservices.org

Confidential Enclosure (for DSS only)
cc: Josh Geballe
Paul Mounds
Rep. Toni Walker
Sen. Catherine Osten
Rep. Catherine Abercrombie
Sen. Marilyn Moore
Sen. Jonathan Steinberg
Sen. Mary Daugherty Abrams
Kate McEvoy, Medicaid Director
Ted Doolittle, Office of the Healthcare Advocate