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Reducing the Health Care Burden Caused by Undocumented Immigrants

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Abstract

Uncompensated health care and Emergency Department (ED) overcrowding are a national crisis in the United States, and uninsured patients are a major contributor. Undocumented Immigrants (UIs) are a large component of the uninsured patient population. The purpose of this study is to evaluate for efficacy and taxpayer value two large-scale potential solutions: Federally Qualified Health Centers (FQHCs), and expanded Medicaid. A brief analysis of smaller-scale solutions is also included. This study utilized a variety of key terms in electronic search databases such as CINAHL Complete, PubMed, and Google Scholar, and only articles published between 2014 and 2018 by peer-reviewed journals or gray literature (*.gov*) were included. Results were filtered for applicability, and studies were excluded that did not include data specifically about UIs. This scholarly project reveals several key points: 1.) UIs contribute more in tax dollars of all types to the US government than they draw out in benefits, rather than the large deficit that is published in the media; 2.) FQHCs provide acceptable primary care to UIs but there are too few of them, and UIs have little awareness of their existence and services; 3.) Expanded Medicaid in its current form will not solve both aspects - ED overcrowding and uncompensated health care - of the UI health care burden; 4.) The most cost effective and quality solutions will focus on shifting health care for UIs to primary care providers rather than EDs.

Keywords: uncompensated health care, emergency department overcrowding, undocumented immigrants, expanded Medicaid, Federally Qualified Health Centers

Introduction

Whether one is liberal or conservative, democrat, republican; libertarian, Tea Party, political wizard or neutral enthusiast, all can agree that the problem of uncompensated health care is quickly becoming a national crisis. Uninsured patients are the flagship for this crisis, and their plights are diverse and complicated. Among these patients are undocumented immigrants (UIs), documented immigrants, limited-English proficient immigrants of all legal statuses, the indigent, and much of the lower-middle class, who generally have incomes too high to qualify for Medicaid, but too low to afford insurance premiums. Even the sharpest think-tank strategists have not been able to solve this problem. The purpose of this study is to focus on the barriers that exist for just one of these subgroups, undocumented immigrants who are uninsured, and to evaluate for efficacy and taxpayer value the various current solutions that have been instituted across the country.

Statement of The Problem

Uninsured patients are a major contributor to uncompensated health care expenses in the United States, an estimated $46.6 billion in 2015 alone (author's own calculations based on Sun, Karaca, & Wong, 2018; Healthcare Cost and Utilization Project [HCUP], 2018). These expenses place a burden on the budgets of federal, state and local government, which in turn, directly impact every taxpayer in the country. Ortega, Rodriguez and Bustamante (2015) report that 57% of undocumented Latino immigrants lack health insurance. Unfortunately, no credible source of data was discovered that cited the portion of the national uninsured population consisting of undocumented immigrants, including all ethnicities. Studies are needed to determine the best solutions for providing quality health care to the uninsured/undocumented immigrant populations in the most cost-effective manner.

Research Question

In adult, non-elderly (aged 18-64) undocumented immigrants, will providing quality primary health care by inclusion in expanded Medicaid, compared with the current Federally Qualified Health Centers (FQHCs), lead to patients receiving more comprehensive and appropriate health care, while reducing Emergency Department (ED) overcrowding and uncompensated health care?

Methodology

A literature review was performed using electronic search databases: CINAHL Complete, PubMed, and Google Scholar. Key word and MeSH terms were used to define various sets of literature, as the topic of this paper is multifaceted. A sampling of the search terms used include: undocumented immigrants AND financial burden, safety-net providers AND undocumented immigrants, community health centers AND undocumented immigrants, health expenditures AND undocumented immigrants, differentials in concentration of health expenditures across population subgroups in the US, Medical Expenditure Panel Survey AND undocumented immigrants, expanded Medicaid AND undocumented immigrants, and ED overuse AND undocumented immigrants. Parallel searches were also conducted, using commonly interchanged key words (e.g. “illegal” was substituted for “undocumented;” “unreimbursed” substituted for “uncompensated;” “ER” for “ED;” “healthcare” for “health care,” etc.). There were no published studies that addressed all, or even most, of the objectives of this paper. Therefore, the results were filtered primarily for applicability, and to include publish dates no earlier than 2014. Studies were excluded because they did not include data specifically about UIs. Google scholar was used primarily to locate gray literature on the various topics, and results were filtered to include only *.gov* websites.

Review of Literature

Recent health care policy changes and increased political divisiveness in the US have contributed significantly to the perpetuation of uninsured immigrants, *legal and illegal*. Uninsured patients, of all ethnicity and legal status, accounted for 11% of ED visits each year in 2015 and 2016 (HCUP, 2018), even after the Affordable Care Act (ACA) was implemented. Current literature shows that steps have been taken at every level of government to provide health care to various subgroups of uninsured patients. Specifically, the literature reveals two large-scale solutions have been attempted: Federally Qualified Health Centers (FQHCs), and expanded Medicaid. Non-profit hospitals, charity organizations and individual providers have also attempted solutions, but there is insufficient data available on these to assess them in this study.

Do UIs Contribute Significantly to ED Overcrowding When Compared to Residents of Other Legal Statuses?

Uninsured patients of all backgrounds and legal statuses have accounted for 11% of nationwide ED visits in recent years (HCUP, 2018). UIs make up an unpublished percentage of that figure. In 2016, Sarría-Santamera, Hijas-Gómez, Carmona, and Gimeno-Feliú conducted a systematic review of studies published between 2013 and 2016. These studies analyzed the use of all forms of health care by immigrants of all legal statuses ranging from those who were foreign-born up through the second generation. Most studies examined European countries, with the purpose being to compare health care use between immigrants and native populations within a country. They found that in some countries, immigrants used health care less than their native counterparts in their country of residence, while in other countries immigrants used health care equally. The study also determined that immigrants did not use health care more than their

native counterparts in any of the studied countries. There are at least two significant limitations of the Sarría-Santamera et al. (2016) study, as it pertains to the United States (US) issue. The first limitation is that only two of the included studies analyzed US data. The second limitation is that the study looked exclusively at patient-provider contact data and did not evaluate the impact of any social barriers or variances such as: legal status - patients avoiding health care due to fear of deportation (Fernandez & Rodriguez, 2017), language barriers, income variations between immigrants and members of the native population, insurance status, health care system in the host country (single payer, multi-payer or hybrid), or the cultural norms for use of health care in the immigrant's country of origin. While it is interesting to know that the global data shows an overall decreased health care use by immigrants when compared to native populations, omission of the aforementioned social factors greatly impairs the usability of this finding in establishing real solutions for UI health care.

Another study, conducted by Tarraf, Vega, and González (2014), evaluated the specific proportion of patient ED use by immigration status. The Medical Expenditures Panel Survey (MEPS) from 2000-2008 data was analyzed to compare ED use among three patient populations in the US: non-citizens that were documented and undocumented, foreign-born citizens, and US-born citizens. MEPS is a federal cross-sectional survey of patients across the nation, and its data is broadly cited in scientific and peer-reviewed articles. Although Tarraf et al. (2014) concluded that non-citizens used the ED the least among the three groups, 8.7%, compared with 10.6% and 14.7% for foreign-born citizens and US-born citizens respectively, the validity of the data collected is questionable, primarily due to the data collection method utilized by MEPS. Specifically, MEPS data is highly subjective, and the respondents are not well targeted/controlled to accurately represent the national population. The survey may have been

provided to a scientifically valid sample of patients across the US, but since response is voluntary, the demographics of the responding population could easily bias the data acquired. Education level, socioeconomic class, immigration status, and ethnic and cultural backgrounds vary significantly across the US. When these differences are combined with imbalanced response rates from targeted patients, then the data, even when obtained from a large population sample, will still not accurately reflect the true health care situation across the country. Furthermore, in addition to the inherently flawed nature of the MEPS data collection, the authors compromised their data further by linking the MEPS data with data from the National Health Interview Survey (NHIS) in order to determine respondents' citizenship status. This was necessary because MEPS does not ask respondents for that information. Further studies based on objective and verifiable data are needed to verify the Tarraf et al. (2014) findings.

Do UIs Contribute Significantly to Public Health Care Expenditures - Including Uncompensated Health Care – When Compared to Residents of Other Legal Statuses?

Academic Health Centers (AHCs) are typically university-based sites that often provide safety-net care. In an article critical of AHCs – outside the scope of this project – Acosta & Aguilar-Gaxiola included data that does relate to this project (2014). Rather than being a burden on American taxpayers, Acosta and Aguilar-Gaxiola asserted that UIs actually contribute to a surplus of taxes – "the nonpartisan Congressional Budget Office reported that undocumented immigrants contribute more in taxes than the costs of providing health care services at the federal and individual state levels" (p. 541). Acosta and Aguilar-Gaxiola reported that during the studied period, it cost the US government $6 to $10 billion annually to provide health care to UIs – through EDs, FQHCs, other programs, and including uncompensated health care – which would have amounted to a total of $11 per taxpayer household in the US (2014). They did not

report the specific amount that UIs paid in taxes annually, but emphasized that it was greater than the amount spent on them for health care.

UIs made up an unstudied portion of the estimated $46.6 billion in uncompensated health care in the US in 2015 (author's own calculations based on Sun et al., 2018; HCUP, 2018). The primary reason for the UI contribution to uncompensated health care is their lack of access to health insurance. Fernandez and Rodriguez (2017) laid out the health care access challenges for UIs in today's political climate of health care reform, and they concluded that UI access to health care is based on politics rather than on cost or an interest in public health. To demonstrate that health care policies lack consideration of cost, Fernández and Rodriguez (2017) reported "…many studies have found that immigrants contribute more via non-income taxes than the cost of the benefits they obtain" and cited a study that concluded during a seven-year period, UIs "supplied $115 billion more [in Medicare contributions] than what they took out in benefits" (p. 536).

In 2013, MEPS data was merged with NHIS data and used by Stimpson, Wilson and Su (2013) to demonstrate that among all subgroups of patients, with regard to legal status in the US, public health care spending was least for UIs each year between 2000 and 2009. They found that $15.4 billion was spent annually on health care for UIs, while health care spending for legal and naturalized immigrants totaled $81.1 billion, and a staggering $1 trillion was spent on US-born citizens. Stimpson et al. (2013) further reported that only 7.9% of UIs even benefited from any public health care dollars during the ten-year study period, and the per capita public expenditures for those UIs was $140. This is contrasted with 30.1% of US-born citizens who benefited from public health care dollars for a per capita total of $1,385 (Stimpson et al., 2013). Once again however, MEPS data is patient-reported data from surveys. Recent, reliable data citing

government dollars spent on health care for these populations does not appear to have been published.

Most recently, a study published by Flavin, Zallman, McCormick, and Wesley (2018) resulted in similar findings to that of the two earlier-referenced MEPS studies, but using more objective data. They conducted a systematic review of PubMed studies since the year 2000 that analyzed how the health care expenditures by and on behalf of UIs compared with that of other populations in the US. The review concluded that not only did UIs have lower health care expenditures than foreign-born citizens or US-born citizens, but they also contributed more toward Medicare than they withdrew (Figure 2, p.12). Specifically, 1.4% of total US health care expenditures were for UIs, yet UIs represented 5% of the total US population. Though health care expenditures were trending higher for all groups of patients each year, the rate of increase for US-born citizens was twice that of the UI rate of increase (Flavin et al., 2018). Very few of the studies reviewed by Flavin et al. (2018) reported specifically on uncompensated health care, but those that did so reported that UIs have more uncompensated visits than US-born citizens. However, they did not specify if the uncompensated visits were from the ED or primary care setting (Figure 3, p. 14).

Benefits of FQHCs for UIs

Per the US Department of Health and Human Services' Health Center Program website (n.d.), Federally Qualified Community Health Centers (FQHCs) are non-profit, comprehensive health care centers that provide primary, preventive, dental, mental health, in-patient hospital, and care-related transportation services on a sliding scale fee basis to underserved populations, regardless of a patient's legal status. They are federally funded through the Health Resources

and Services Administration (HRSA) and are eligible for extra Medicare and Medicaid reimbursement.

UIs are ineligible for all federally funded health insurance, such as Medicare, Medicaid, and CHIPs. Private insurance companies have unanimously excluded UIs from eligibility as well. Therefore, the only places for UIs to receive primary health care are FQHCs, health centers devoted exclusively to migrant workers, or provider sites that accept cash-pay patients, other than the occasional private non-profit charity program (Gusmano, 2012). The only other source of health care available to UIs are EDs, which are the most expensive and least efficient platform for administering primary care (Tarraf et al., 2014). And although UIs are eligible for health care at FQHCs, there is remarkably little public or community awareness of this fact.

Michael Gusmano, co-director of the Undocumented Patients project within the Hastings Center, a bioethics research institute, was among other experts who made predictions in the pre-Affordable Care Act era that the budget for FQHCs would be reduced (Gusmano, 2012). This was based on the theory that since more people would be insured under the ACA, the federal government would expect the need for safety-net programs like FQHCs to decline. Even in the midst of ACA implementation, experts such as Ortega, Rodriguez, and Bustamante (2015) had budgetary concerns, though rooted in politics rather than economics. There was concern that the immigration political hotbed could result in drastically reduced funding for the FQHCs, which would be detrimental not only to the UIs, but to all states with heavy UI populations, as they scramble to find independent solutions (Ortega et al., 2015). But between 2012 and 2015, the HRSA's annual federal appropriations for primary care programs, which includes FQHCs, increased from $2.8 billion to $4.6 billion, and the budget has remained steady at about $5 billion for the last 3 fiscal years (US Department of Health and Human Services, 2015, 2018).

While steady budgets are better than budget cuts, they also mean minimal or no growth in establishment of additional FQHCs to meet growing needs. Figure 1 is a Medicare and Medicaid map of all the FQHCs that were available as of 2010, published by Gusmano (2012). A current map could not be located to offer as comparison, but it offers a powerful visual representation of the regions with greatest access to FQHCs, and by contrast, those regions that are underserved. States sharing a border with Mexico generally have a far lower concentration of FQHCs than the eastern and western coastal states.

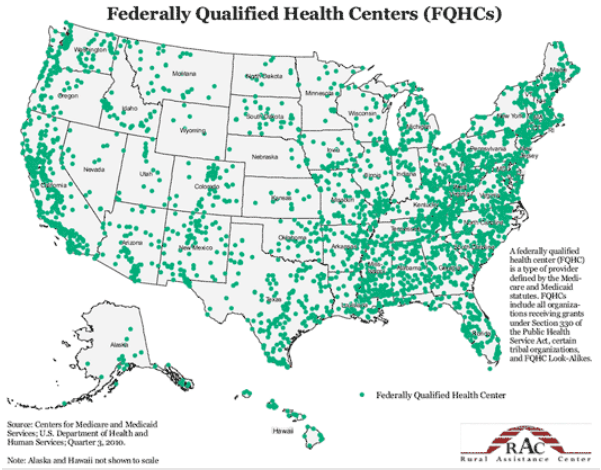

Figure 1. Locations of all FQHCs existing in 2010 (Gusmano, 2012)

Figure 2 shows a comparison of the ten states with the largest UI populations, and the numbers of FQHCs available in each state. Using that data, Figure 3 demonstrates the potential heavy FQHC caseloads and extended distances patients could have to drive to reach an FQHC.

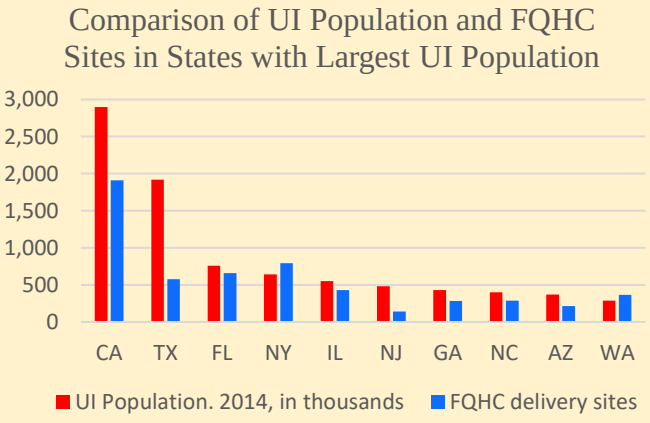

Figure 2. Numbers of available FQHC sites per thousand UIs in the ten states with largest UI population (based on data from Baker, 2017; HRSA, 2018)

Texas, Arizona, and New Jersey have the least availability of FQHCs. Furthermore, the data shows that the states sharing a border with Mexico (all except New Mexico) are underserved by FQHCs, and the graph reveals that much work is needed to increase the numbers of FQHCs in these states, as well as in New Jersey.

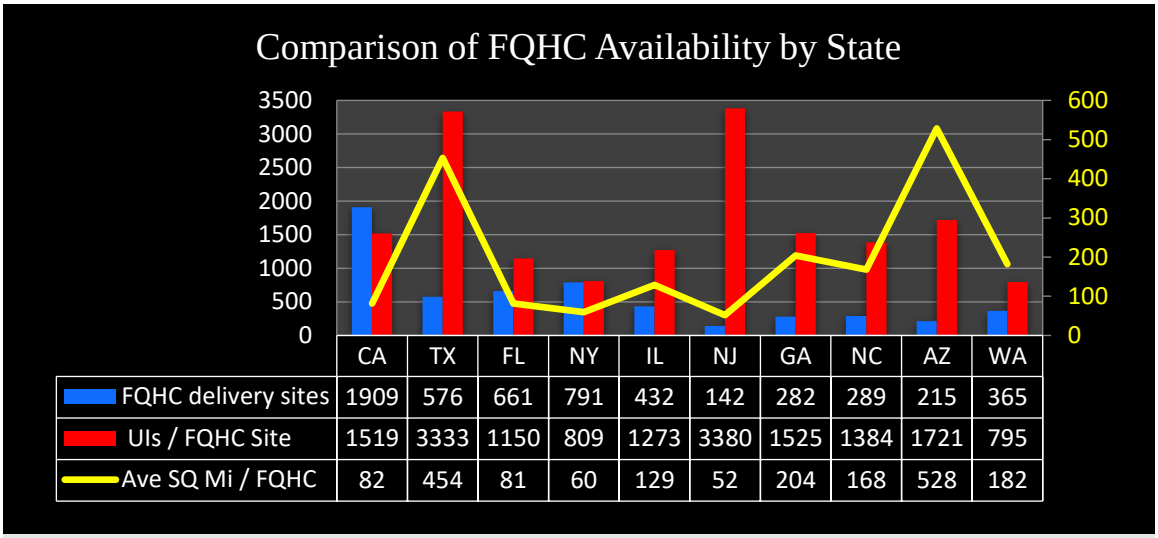

Figure 3. Among the ten most UI-populous states, this graph compares the FQHC factors that could impact UI access to those FQHC sites. (based on data from Baker, 2017; HRSA, 2018; United States Census Bureau, 2010)

Primary Health Care Successfully Reduces ED Overcrowding

In 2011, a non-profit hospital implemented a free adult primary care clinic within the hospital for poor uninsured patients. Tsai, Xirasagar, Carroll, Bryan Gallagher, Davis, and Jauch (2018) conducted a retrospective study of ED visits two years before and three years after the 2011 implementation of the primary care clinic, evaluating for efficacy in reducing avoidable ED visits. The authors reported that during the three-year intervention period, 41.7% of pre-intervention high-users – patients who had three or more ED visits in the pre-intervention phase – did not return to the ED at all. A limitation of the study is that Tsai et al. did not track or report on the reasons those patients did not return, and therefore cannot demonstrate the portion of that 41.7% who did not return as a direct result of the intervention. However, the study did demonstrate that high-users who did return, did so with reduced frequencies of between 28% and 68%, and with more ED appropriate severity of illnesses. High-users who had very high severity of illness in the pre-intervention phase presented to the ED with lower severities in the post-intervention, which the authors presumed to be a result of the benefits of primary care on their

severe chronic illnesses. Conversely, high-users with very low severity of illness in the pre-intervention phase presented to the ED with higher severities in the post-intervention phase. "…More patients may have used primary care, resulting in less need for ED visits, and when they used the ED, it was more appropriate, for emergent needs" (Tsai et al., 2018, p. 26). This study appeared to show that providing primary care to uninsured patients reduced their avoidable ED usage, particularly among high-volume ED users. However, the article reports that several similar studies have been done with little to no reduction in ED use. Tsai et al. (2018) concluded that success with this program depended on uninsured patients being given insurance that required them to stick to one primary care provider, meaning a single primary care provider who assumed responsibility for fulfilling the primary care role for that patient.

Primary Health Care Successfully Reduces Uncompensated Health Care

It has long been assumed that communities with higher Latino populations will have higher levels of uncompensated care. Chen et al. (2015) evaluated California hospital data from 2000-2010 to determine if there truly was such a correlation. They found that in 2012, $45.9 billion was spent in uncompensated health care, according to the American Hospital Association, which totaled 6.1% of hospital expenses for the year (Chen et al., 2015). The study concluded that while a superficial look at communities seemed to show that those with a large growth in Latino population - of all legal statuses - were associated with increased uncompensated care, the various mitigating considerations reduced this association to statistically insignificant. The study did not provide an in-depth analysis of those mitigating considerations, nor a P-value for the lack of statistically significant association with increased uncompensated care, but allowed for the likelihood that the larger communities were most likely equipped with more robust and integrated solutions such as safety net health care, not-for-profit hospitals, charitable health care

provider systems, and in-hospital primary care. Regardless of the population considered, the authors concluded that improving hospital resources and developing integrated health care systems that include primary care for patients with major chronic illnesses is essential to promoting efficient and coordinated health care and controlling hospitals' uncompensated care.

Benefits of Expanded Medicaid for UIs

Expanded Medicaid as a provision of the ACA has made drastic improvements to previously uninsured patients. In a study published by Vistnes, Lipton, and Miller (2016), changes in insured status among patients of many health categories as a result of State Medicaid Expansion were evaluated. They found that previously uninsured patients were now insured, and fewer insured patients lost their insurance. The study also concluded that patients in fair to poor health were more likely to be covered by expanded Medicaid, while those in good to excellent health were more likely to obtain private or other public insurance. A glaring problem with Expanded Medicaid as it relates to UIs is that this population is ineligible to receive coverage under federal Medicaid.

Kelley and Tipirneni (2018) suggested a potential solution in the form of Medicaid waivers. Federal Medicaid waivers offer states some flexibility in covering health care funding deficits in ways that Expanded Medicaid cannot, specifically with respect to health care for UIs. As previously cited, the federal government has prohibited eligibility of UIs to receive Medicaid in the traditional format. In fact, there are only a few ways that federal dollars can be applied toward UI health care at all. Those include "…hospital reimbursements for uncompensated care, Medicaid funds for emergency services, and grants to community health centers" (Kelley & Tipirneni, 2018). The Affordable Care Act was ushered in by a federal administration that was strict about leaving UIs out of the health care mix entirely. It aimed at enforcing near 100%

insured status of all legal residents, which would reduce the projected expenditures on uncompensated care. While the current federal administration has been strict about reducing the physical presence of UIs in the US, it has simultaneously loosened up the ability of states to cover/prevent UI-related uncompensated care by granting Medicaid waivers. Florida and Texas have seen their uncompensated care funding increase by as much as 70% as a result of the waivers. Other states, such as California, have chosen to accept Expanded Medicaid, and then fund care for UIs using only state funds (Kelley & Tipirneni, 2018). Time and further study will reveal which solution is more cost effective and provides the best health care option for UIs and their communities.

Expanded Medicaid Successfully Reduces ED Overcrowding

In the first year after implementation of the ACA, California opted to participate in expanded Medicaid, while Florida did not. Barakat et al. Mithal, Ad, Huang, Mithal, Al, Sehgal, Banaerjee, and Singh released a study in 2017 that evaluated the effects of expanded Medicaid on the hospitals and EDs in each of these states for 2014, and found that there was a modest increase in ED visits in California when compared to Florida. Two opposing arguments can be made intuitively regarding predicting whether increasing the number of insured patients would result in reducing versus increasing ED visits. The first argument is that if patients now have access to primary care, they should not need ED care as frequently. The opposing argument is that these patients have been habituated to receiving their primary and emergent care through the ED, and the only difference is the payer, which has changed from self-pay to Medicaid. Furthermore, this population can now seek treatment in the ED for previously deferred treatment since their visits are funded through expanded Medicaid. The authors also concluded that the relatively small increase in ED visits could have been due to the fact that for 2014 (the study

year), the government increased funding for Medicaid reimbursement to raise it from the Medicaid standard of 56% to Medicare's standard of 80% (Barakat et al., 2017). This meant that a greater number of physicians were likely willing to accept Medicaid patients during that year than in normal reimbursement years. Additional studies are needed to determine whether ED visits skyrocketed in 2015 when the adult Medicaid reimbursement dropped back to 56%, which could have occurred if physicians stopped seeing adult Medicaid patients once again, limiting their access to primary care.

An analysis by Nickpay, Freedman, Levy, and Buchmueller (2017) after implementation of the ACA, including expanded Medicaid, agreed with the observations of Barakat et al. regarding increased ED visits in Medicaid expansion states, although the amount of uncompensated ED care decreased. If longer-term analysis shows continuance of this trend, then expanding Medicaid will not be effective at reducing ED overcrowding unless countermeasures are added to handle the increased volume. More analysis is needed to determine whether the increased volume of ED visits would return to previous levels and to determine whether there were other reasons for the increased ED volume that are unrelated to expanded Medicaid.

Expanded Medicaid Successfully Reduces Uncompensated Health Care

Barakat et al. (2017) concluded that expanded Medicaid in California resulted in a 33% increase in ED visits by Medicaid patients and a 25% decrease in ED visits by self-pay patients, while Florida, which opted out of expanded Medicaid, experienced a 5.7% increase in Medicaid ED visits, and a 5.1% decrease in self-pay ED visits. In other words, expanding Medicaid likely triggered an overall increase in ED visits, but it shifted the payer from self-pay to Medicaid. Because self-pay patients were large contributors toward uncompensated health care, this meant

expanded Medicaid resulted in a reduction in uncompensated health care. Nickpay et al. (2017) also concluded that expanded Medicaid reduced uncompensated ED care.

By comparing data from the three years prior to the implementation of expanded Medicaid with the data from the first year of its implementation, Selden, Abdus, and Keenan (2016) were able to demonstrate a dramatic impact of expanded Medicaid. There was a 47% reduction - 19.8% down to 10.5% - in ED visits by uninsured patients and a 33% reduction - 8.4% down to 5.6% - in physician visits by uninsured patients, which was directly attributable to expanded Medicaid. This was contrasted with no measurable differences in uninsured patient visits to either EDs or physicians in the non-expansion states (Selden, Abdus & Keenan 2016).

Solutions Analysis: FQHCs, Expanded Medicaid and Other Solutions

FQHCs

The current network of FQHCs is serving in a safety-net capacity. They serve a substantial number of UIs, and the care they provide is generally considered to be acceptable. The *American Journal of Preventive Medicine* published findings from a cross-sectional study in 2012 that concluded that FQHCs "demonstrated equal or better performance than private practice PCPs [Primary Care Providers] on select quality measures despite serving patients who have more chronic disease and socioeconomic complexity" (Goldman, Chu, Tran, Romano, & Stanford, 2012, p. 142). However, the following year, *Ethnicity & Disease* released a qualitative study that showed that care at FQHCs was lacking in other factors when compared with private primary care sites. Specifically, at FQHCs there was typically no designated provider assigned to patients. Instead, patients were seen by whichever provider was available. This frequently led to disjointed and inefficient care, and the patient lacked a provider advocate committed to his/her comprehensive care. FQHCs also experienced high staff turnover, stressful work environments,

and limited resources. Additionally, FQHC providers often reported difficulties in securing referrals to specialty care for their patients (Quinn, Gunter, Nocon, Lewis, Vable, Tang, … Chin, [2013]).

Expanded Medicaid

Because UIs have been specifically prohibited from receiving federal funding in the form of Medicaid, states with large UI populations have not generally found that expanded Medicaid is their best solution. Kelley and Tipirneni (2018) looked at the effects of the Presidential administrations and the political climate and how states can best cover the financial burdens of the uninsured, including undocumented immigrants. They reported that Republican administrations have shown to be more flexible and generous with granting Medicaid waivers than Democratic administrations. The authors also concluded that the waivers allowed states to be more creative with how they applied federal dollars toward solving their particular health care challenges. States that accepted expanded Medicaid were less likely to get Medicaid waivers approved of course, which meant no increased funding for safety net hospitals to help reduce the UI contribution to uncompensated health care. This has meant that states that did not accept expanded Medicaid, but received Medicaid waivers instead, were able to increase their funding by 50 to 70% for uncompensated care and potentially direct that cash flow toward safety net hospitals that care for UIs (Kelley & Tipirneni, 2018). The authors readily acknowledged, however, that no one can be certain how the policies and politics will change in the near future, much less decades from now. As a result, Medicaid waivers are by no means a reliable solution.

Other Solutions

Ortega et al. (2015) pointed out that "given the relatively young age and healthy profiles of undocumented individuals, extending the eligibility guidelines for ACA insurance exchanges

or Medicaid expansion could help offset the anticipated high costs of managing other patients with multiple chronic conditions" ("Introduction" para. 5). In other words, they asserted that including UIs in the insurance pool and allowing them to access quality primary care would potentially decrease the costs of not only their health care, but because they are generally young and healthy, their insurance premiums in the insurance exchanges could help offset the health care costs of other more-costly insured patients (Ortega et al., 2015).

A different solution was attempted at the local governmental level. New York City's mayor was a national pioneer in 2015 when he commissioned the development and launch of a pilot health care program, "Direct Access," aimed specifically at meeting the needs of UIs. Direct Access provided a range of health care to a small group of UIs, about 1,300, in New York City (Mayor's Office of Operations, 2015). The mayor closed the program in 2017 without explanation but indicated hope for a future program that can meet the same needs on a much larger scale (Pazmino & Goldberg, 2017). Though this program did not endure or succeed at transitioning into a citywide or nationwide program, it did bring hope that innovation at the local governmental level may one day be emulated nationwide resulting in equal access to quality, affordable healthcare for UIs across the country without causing an undue burden on taxpayers.

Discussion

This scholarly project sought to determine whether including adult UIs in Expanded Medicaid would be a better solution than FQHCs for providing comprehensive and appropriate health care while reducing ED overcrowding and uncompensated health care.

Solving the problems of ED overcrowding and uncompensated health care created by uninsured patients has been a concern in the US for decades, and yet comprehensive solutions remain elusive. Undocumented immigrants in the US are specifically excluded by both public

and private insurance programs, leaving EDs and FQHCs as the only sources of health care available to most. Reducing the health care burden of UIs must include reducing their ED usage and providing them access to health insurance, thus helping to relieve ED overcrowding and reducing uncompensated health care.

The most unexpected finding in this scholarly project was the drastic difference in reported dollars spent on health care for UIs between the media and other non-scholarly sources when compared to those published by government and peer-reviewed, scholarly sources. The political platforms prolifically publish in the media unsubstantiated information that falsely reports that UIs are costing the average Americans an exorbitant amount in public services. Nevertheless, reputable and peer-reviewed studies continue to report a tax surplus afforded by UI contributions. It became apparent during this study that the information most readily available to the public is sensational, insufficient, unreliable and indubitably false. Factual, credible data on the matter is scarce and extremely difficult to locate, which is discussed further in the next paragraph. UIs contribute to a net economic surplus, even after considering the cost of their health care. There is no valid excuse for why these facts not distributed to the public. Public opinion fuels policy decisions, and agenda-driven politicians feed public opinion; and, politicians' agendas are fueled by backers and special interests. So the disheartening fact is that public policy is being driven by all the above machinations and is based on the errant information that informs them, to the great detriment of finding effective solutions.

The first shortcoming of this study was the inability to conduct a single or limited number of systematic searches of related studies or articles and filter the results using a prescribed set of inclusion or exclusion criteria. The only filters and inclusion criteria that could be applied across all searches were: published between 2014 and 2018, and they contained data or analysis relating

to this paper's topics. All articles that met these criteria were included. It was necessary to conduct separate searches for each theme, and often multiple separate searches within each theme were required in order to locate all recent data from reputable studies and articles that related to this study. At times, no such studies were located that supported or disproved certain topics, such as the annual uncompensated care dollar amount attributed to UIs. In these cases, it was necessary to use Google Scholar to search for gray literature on ".gov" websites and piece together the needed data using multiple sources and, at times, this author's own calculations. The effect of this issue on the public is so pervasive, that any reasonable expense required to publish an annual report on actual public expenditures for UI and other uncompensated health care is well justified. It is incumbent upon the US government to disclose financial data and other facts that would significantly affect policy and voting decisions. The timely and accurate reporting of the balance of income and expenditures related to UIs is certainly such a topic. The public should demand this information be collected and published by the government annually so that members of the public are aware of the true situation, and so that lawmakers can base their decisions on solid evidence.

When looking at FQHCs as a potential solution, the problem is not so much the care provided, though there is evidence that improvements may be needed, but the appalling lack of public awareness of their existence and offerings. It is well established that primary care is a cheaper health care delivery platform than EDs, so it is fiscally irresponsible that the federal government fails to advertise FQHCs in communities with high populations of uninsured. Any concerted effort to reduce ED use and its associated uncompensated health care should have long-since included intensive efforts to disseminate this information to UIs so they can use the appropriate available resources and receive more comprehensive care in the process.

The second shortcoming of this study was the assumption that previously uninsured patients who are provided with Medicaid would automatically start seeking primary care in a primary care setting, thereby reducing their ED use. This is the other unexpected finding, that while Expanded Medicaid does reduce uncompensated health care, it has been shown to increase ED use and overcrowding, at least in the short-term. Therefore, the notion that Expanded Medicaid Successfully Reduces ED Overcrowding, was found to be false. Longitudinal studies are needed to determine whether new Medicaid patients will decrease their ED use over time. If not, then studies to determine the root cause for the increase will be warranted. Is it due to lack of education on the benefits of primary care? Is it because relatively few primary care providers will accept adult Medicaid due to reduced reimbursements? Is it because Medicaid patients are typically blue-collar workers who cannot afford to take off work for primary care appointments during business hours? Or is it simply a matter of habit or the convenience of visiting the ED instead of waiting on a primary care appointment? Once the reasons are understood, solutions can be crafted. Thus far, based on the data available to date, Expanded Medicaid will decrease the burden of uncompensated health care while simultaneously increasing the burden of ED overcrowding.

There are various problems associated with many proposed or attempted solutions. Sarría-Santamera et al. (2016) found that immigrants use health care significantly less than their native counterparts. Ortega et al. (2015) reached the same conclusion and used it as a basis for why it would be cheaper to offer insurance to UIs than to continue funding their health care through uninsured ED visits. Regardless, the question must be asked: would UIs use health care equally or more frequently than the native population if barriers such as legal and insurance status, income and language differences were removed? Even if UI health care use remained

much lower than the that of the native population, this solution still does not address the fact that many UIs are below the poverty line and would not be able to afford insurance premiums unless subsidized through a federal program like the ACA marketplace.

The most effective solution will be the one(s) that results in uninsured patients using primary care. Tarraf et al. (2014) reported that "uninsured non-citizens delay use until they reach more acute, and likely resource intensive, levels of healthcare needs" ("Discussion" para. 4). By enabling and encouraging the use of primary care, chronic illnesses can be treated before they become acute, which will reduce overall health care spending. A combination of targeted outreach to newly arrived immigrants will be necessary. According to Tarraf et al. (2014), "…through workplace, churches, and schools…[policy solutions will need to] use community resources and culturally appropriate channels to increase and instill awareness about correct healthcare habits" ("Discussion" para. 6).

This scholarly project collected current data on and findings from various attempts to create solutions for the health care burden caused by undocumented immigrants, and it reveals several key points. The first is that UIs contribute more in tax dollars of all types to the US government than they draw out in benefits, which disputes the erroneously published information disseminated by the media. The second key point is that FQHCs provide acceptable primary care to UIs, but there are too few of them, and UIs have little awareness of their existence and services. The third is that expanded Medicaid in its current form will not solve both aspects - ED overcrowding and uncompensated health care - of the UI health care burden. Finally, the most cost effective and quality solutions will focus on shifting health care for UIs to primary care providers rather than EDs.

Application to Clinical Practice

The aim of this scholarly project was to determine if expanded Medicaid offers a better option for reducing ED overcrowding and uncompensated health care than do the current FQHCs for adult, non-elderly, undocumented immigrants. The causes of ED overcrowding and uncompensated health care are complicated, and no single solution has shown to clearly be the best practice. Expanded Medicaid does reduce uncompensated care, but at the expense of increasing ED overcrowding, at least in the short-term. The network of FQHCs have shown to generally provide acceptable care, and studies have demonstrated that providing dedicated primary care - which means that patients are required to stay with one primary care physician to ensure coordinated care - has the potential to reduce ED overcrowding.

Now, more than ever before, Physician Assistants (PAs) can, and should, play a vital role in helping to solve these problems. Their participation as part of a multi-level medical team of providers can contribute to reducing ED overcrowding and uncompensated health care in several ways. Most directly, PAs can work directly at an FQHC. Less directly, but of equal importance, PAs can work in rural, underserved communities. The highest concentrations of FQHCs are understandably in urban areas where the populations are highest. But UI populations do not align proportionately with FQHC location densities. The more PAs and physicians who are willing to work in rural underserved areas, the greater the opportunity to provide the needed primary care to UIs which can lower ED overcrowding and uncompensated care.

For providers not interested in working in either of these settings, there are still two instrumental initiatives they should personally adopt to help to resolve these problems: the incorporation of dedicated, charitable care as a planned portion of their caseload and the ongoing quest to stay informed about the most current primary health care resources available to UIs and

other uninsured patients so that they can be committed to referring patients to those resources. Incorporating dedicated charitable care should involve taking on a certain number of patients whose dedicated, comprehensive care is offered free-of-charge or at a reduced cost, rather than just setting aside a random portion of patient appointments or allotting a predetermined dollar amount worth of charitable care. Comprehensive and dedicated primary care has been shown to have the greatest effect on reducing ED overcrowding. As evidenced in this scholarly project, the primary care resources available to UIs and other uninsured patients vary greatly across the country and depend mostly on specific steps taken at the state and local governmental level. It is of utmost importance that PAs hold themselves accountable for knowing the resources available to uninsured patients in their local area and are diligent about helping them access those resources. Taking these steps can and will have a widespread impact on reducing ED overcrowding and uncompensated health care. These reductions will ultimately increase the availability of healthcare to all populations, as well as increase the quality of that healthcare.

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