

Health Policy, Disparities, and the Kidney



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Kidney care and public policy have been linked for 40 years, with various consequences to outcomes. The 1972 Social Security Amendment, Section 2991, expanded Medicare coverage for all modalities of dialysis and transplant services and non-kidney-related care to those with end-stage renal disease (ESRD) regardless of age. This first and only disease-specific entitlement program was a step toward decreasing disparities in access to care. Despite this, disparities in kidney disease outcomes continue as they are based on many factors. Over the last 4 decades, policies have been enacted to understand and improve the delivery of ESRD care. More recent policies include novel shared-risk payment models to ensure quality and decrease costs. This article discusses the impact or potential impact of selected policies on health disparities in advanced chronic kidney disease and ESRD. Although it is too early to know the consequences of newer policies (Affordable Care Act, ESRD Prospective Payment System, Quality Incentive Program, Accountable Care Organizations), their goal of improving access to timely patient-centered appropriate affordable and quality care should lessen the disparity gap. The Nephrology community must leverage this dynamic state of care-delivery model redesign to decrease kidney-related health disparities.

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Understanding the dynamic factors contributing to health disparities and designing effective interventions embedded into health-care systems has been a challenge for the health-care profession and policy makers. Historically, disease state and disability led to disparities as illustrated by the rationing of renal replacement therapy (RRT) in the 1960s. At that time, selection for dialysis or transplant was based on a number of criteria: age, income, education, occupation, and the likelihood of returning to a productive life.^{1,2} In 1965, Medicare was enacted to provide health insurance for those 65 years or older, decreasing age-based health disparity. In 1972, this benefit was extended to all who were disabled regardless of age. This Social Security Amendment, signed by President Richard M. Nixon on October 30, included Medicare coverage for those “disabled” with end-stage renal disease (ESRD) resulting in expanded access to dialysis and transplant beginning July 1, 1973.³⁻⁵ It remains the only disease-specific entitlement program with coverage for all modalities of RRT (dialysis and kidney transplant) and non-kidney-related services regardless of age. The immediate impact in 1973 was the option of RRT for more than 90% of individuals in the United States. Unfortunately, although allowing payment for RRT, it did not address other barriers to access care or the numerous socioeconomic variables shown to affect patient outcomes. To understand the consequences of this entitlement funding, in 1977, the Healthcare Finance Administration established a data system requiring annual reports from dialysis providers.⁶ This was followed by the US Renal Data System (USRDS), an independently contracted agency charged with monitoring ESRD/RRT practices

and outcomes.⁷ The goal was to establish best practices and initiate studies to improve care through objective analysis of ESRD treatment data. The 1991 Institute of Medicine report “Kidney Failure and the Federal government” outlined the quality of ESRD care and drove the focus toward care processes, and patient-meaningful outcomes, including health-related quality of life and functional status.⁸ This was an important transition introducing shared responsibility partnerships between providers, payers, and patients. Sharing large data was essential to better understand variations in care based on treatment site and patient demographics and a step to identify and target interventions to decrease health disparities within this disease-specific population.

As with overall trends in complex chronic disease management and health care in the United States, the cost of the ESRD program outpaced the expected rate.⁹ The causes are multifactorial, including the aging population, increasing numbers and complexity of comorbid diseases, new technology and therapeutic options, and overall increased survival of those receiving RRT. In addition, the higher ESRD rates in populations at risk for health disparities (African-Americans, Native Americans, Hispanics) and increasing numbers of minority individuals needing health care were not anticipated with the initial amendment.¹⁰ In January 2011, to better manage ESRD care’s rising cost, the Centers for Medicare and Medicaid Services (CMS) initiated a bundled case mix-adjusted payment system for outpatient dialysis-related services, the ESRD Prospective Payment System (PPS).¹¹ A year later, CMS launched a novel, unpiloted pay-for-performance program: the “ESRD Quality Incentive Program” (QIP).¹² Reimbursement was now dependent on meeting quality standards, not solely based on the volume of services delivered. The initial Medicare entitlement program for ESRD has been termed a “social contract” between the government and the ESRD population, promising financial coverage for ESRD care and the responsibility to contain costs and ensure equitable quality care.¹³ Unfortunately, over the 40 years, the “contract” has been in place, costs were not contained, and disparities in outcomes and access to evidence-based quality CKD/ESRD care have

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become evident. More recently, the Patient Protection and Affordable Care Act (ACA) extended many of the same “social contract” elements to the general population with initial goals of aligning health-care cost inflation with overall economic growth and providing access to appropriate evidence-based services.¹⁴ To assess whether these new legislative policies diminish health disparities, we must determine whether they influence modifiable factors leading to disparities. Specifically, will the emerging policies of the ACA along with ESRD PPS and QIP help improve access to timely appropriate kidney care, lessen barriers associated with socioeconomic status, and assure patient-centered care?

Insurance Reform and Access to Care

Lack of access to care is associated with health outcomes disparities. In the Atherosclerosis Risk in Communities study, black individuals were more likely to lack health insurance and less likely to access health care. This inadequate access to care was independently associated with increased risk of CKD.¹⁵ Increased cost, mortality, morbidity, and progression to ESRD and lower referrals for kidney transplantation are associated with delayed nephrology referral and are more common among minorities and those of low socioeconomic status.¹⁶⁻¹⁹ Others have shown that lack of private insurance, black race, and being younger are risks for not being assessed for kidney transplantation.²⁰ The goal of extending insurance coverage to all Americans under the ACA is laudable and if obtained should be a step toward improving access for many who currently are without preventive services and adequate chronic and acute care management. Eliminating the barrier of pre-existing disease to obtain affordable health insurance is also a positive step for those with advanced CKD or risk factors for CKD. As the public and private insurance exchanges roll out, there are worries that premium costs for the public options will be too high for those whose income is just above the cutoff for subsidized health insurance, and the low-cost private plans may not cover subspecialty and tertiary care options best suited to manage complex chronic disease, possibly leading to a new demography with inadequate or no health insurance and, thus, without access to timely, appropriate care. In addition, undocumented residents are not eligible to participate in the public insurance exchange. In 2001, the Institute of Medicine reported that foreign-born US residents are 3 times more likely to be uninsured than US-born residents.^{21,22} Of foreign-born residents, noncitizens are twice as likely to lack insurance as citizens.²¹ Amplifying this disparity is the growing immigrant population in the United States with many having

risk factors for CKD and health disparities. Eligibility for Medicaid has changed over the last 18 years with current eligibility for noncitizens varying by state.²³ Adding to confusion is the debate over whether chronic dialysis is an emergent medical need eligible for Medicaid. Again, the rules differ depending on geography, steering those in states without Medicaid coverage for maintenance dialysis to use emergency departments as entrances for dialysis services, potentiating a system of fractured high-cost care for this complicated chronic illness. Of surveyed US nephrologists, 65% provided care to undocumented immigrants with 35% providing uncompensated outpatient dialysis to undocumented ESRD patients.²⁴ The complexity of the Medicare laws and no standardized national policy for the care of undocumented individuals with ESRD becomes increasingly worrisome as dialysis payments and the ability of dialysis systems to cost shift decrease.²¹ Without means to pay, undocumented residents have few opportunities to access care or establish a trusted relationship with the health-care system. It appears there may be new and growing populations with less access to health care,

further widening the health disparity gap.

For many without means to pay for health care, public hospitals and community clinics have served as a safety net, caring for these individuals at times of acute or subacute care needs. The funding of these facilities, usually in poor urban or rural areas, is based on the expectation that they will serve as a last resort for those without insurance, including those with CKD. With the ACA insurance reform, and anticipated decline in the uninsured, future funding for these facilities

is planned to decrease. Unfortunately, as outlined earlier, the impact on the number of uninsured is unclear. If funding cuts occur without a proportionate decrease in the numbers of uninsured, these safety-net services are at risk. As with the private provider systems, to gain efficiencies and achieve better patient outcomes, many safety-net hospitals are becoming integrated with community services and clinics to provide more co-ordinated care. Although there are many barriers to longitudinal, effective care for many ethnic and socioeconomic groups, the move to more integrated community care within the safety-net public network should benefit those with complex, progressive chronic disease, such as CKD.

Access to Quality Health Care

Health disparities are also evident in the inequitable access to quality or valued care. For those with complex or progressive chronic illness requiring co-ordinated multispecialty care, this can be even more challenging. The initial amendment extending Medicare coverage to ESRD did

CLINICAL SUMMARY

- The inclusion of ESRD in Medicare coverage introduced shared responsibility partnerships between providers, payers, and patients. This was extended with the initiation of the ESRD Quality Incentive Program.
- More integrated community care within safety-net public networks should benefit those with complex, progressive chronic diseases such as CKD.
- Inconsistency in Medicare coverage for chronic dialysis and policies to care for undocumented individuals will potentially lead to further widening of the health disparity gap for certain populations.
- Ongoing monitoring of the evolving ESRD program's effects on the delivery of care for diverse populations is important.

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