Unification of the Voice of Nephrology Stakeholders

Edward R. Jones

Kidney Care Partners is a coalition made up of representatives from the entire kidney community. Its mission is to ensure that chronic kidney disease patients receive optimal care, lead quality lives, and have ready access to dialysis care. The coalition focuses on consensus building and a community-wide cooperative effort toward developing health policy in the interest of patients. Presently, end-stage renal disease care is underfunded, and factors such as an aging population and an increase in obesity are leading to increased demands on the system. Changes in reimbursement for erythropoiesis-stimulating agents will further challenge this system. Kidney Care Partners is strongly promoting health policy through the support of the Kidney Care Quality and Education Act of 2007 (HR 1193/S 691). Among their activities is the formation of the Kidney Care Quality Initiative in an effort to bring consensus to the development of usable quality measures.

Index Words: Kidney Care Partners; Health care policy; Dialysis stakeholders; End-stage renal disease legislation

Kidney Care Partners (KCP) is a coalition of the entire kidney care community representing patient advocates, dialysis professionals, care providers, researchers, and manufacturers working together to improve the quality of care all chronic kidney disease (CKD) and end-stage renal disease (ESRD) patients receive.[1] The mission of the organization's membership, individually and collectively, is to ensure that (1) CKD patients receive optimal care, (2) CKD patients are able to live quality lives, (3) dialysis care is readily accessible to all those in need, and (4) research and development lead to enhanced therapies and innovative products. KCP's approach to the development of policy has been prescribed consensus building, allowing individual members' input as the community works toward developing policy positions that are in the best interest of our patients.

Snapshot of Kidney Disease Today

A looming health crisis exists in the United States because of an increasing population of dialysis patients and inadequate Medicare reimbursement for patient care.[2] In addition to the increasing age of the population and the attendant chronic health care needs, this crisis is worsened by exploding cases of obesity, high blood pressure, and diabetes, all of which can lead to kidney failure. The growth of the ESRD population has the potential of outstripping the supply of nephrologists and requiring alternate models of care. Inadequate funding for dialysis and CKD clinics may limit access of care. Changes in erythropoietin reimbursement and inadequate reimbursement for physician efforts in the CKD clinic setting has already resulted in some CKD clinics to discontinue operation with subsequent referral of patients to hospital clinics (Jones E, personal communication, March 2007).

It is a startling fact to realize that over 600,000 Americans have CKD stage 4 and 5. Many are unaware that they even have this disease and its health implications.[3] Approximately 400,000 patients suffer from ESRD requiring a minimum of 3 hours of dialysis 3 times a week. The only alternative to dialysis is a kidney transplant from a living or deceased donor.

Kidney Care Quality and Education Act: KCP Priority

Today, KCP focuses on the enactment of the Kidney Care Quality and Education Act (KCQEA) of 2007 (HR 1193/S 691),[4,5] which

---

From Kidney Care Partners, Philadelphia, PA.

Address correspondence to Edward R. Jones, MD, MBA, Chairman, Kidney Care Partners, 2550 M Street NW, Washington, DC 20037. http://www.kidneycarepartners.org

1548-5595/08/1501-0005$34.00/0
doi:10.1053/j.ackd.2007.10.003

will have a positive impact on the delivery of quality care to patients with CKD and ESRD. The bill embodies the major agenda of KCP, including patient education, quality improvement, and payment reforms. One of the most important aspects of the legislation is that it links a critically needed 3-year annual inflation update to quality improvement. The reforms are designed to modernize Medicare's ESRD benefit.

To date, this year, we have seen increasing bipartisan support on Capitol Hill around this important piece of legislation. In 2006, over 30 senators and 150 members of the House of Representatives had cosponsored a similar legislation entitled "The Kidney Care Quality and Improvement Act." The newly refined legislation was introduced at the end of February, and, today, we have 106 cosponsors in both the House and Senate.

As noted, many patients are unaware that they have CKD.[3] There is strong evidence that early detection and treatment can slow and indeed stop the progression of CKD to ESRD.[6-8] A major reason for the gaps in disease identification and delivery of optimal medical care is a lack of education of patients. Medpac has reported on the widening gap between the increasing cost of high-quality care and the reimbursement levels provided through the Medicare program.[9] In fact, this gap in funding has become so significant that kidney dialysis clinics have been forced to close in several parts of the country in recent years, a trend providers and caregivers alike regard as concerning.[10]

The KCQEA, sponsored by Senator Kent Conrad (D-ND) and Representatives John Lewis (D-GA) and Dave Camp (R-MI) in the House, specifically would accomplish the following:

1. Create public and patient-education initiatives to increase the awareness about CKD and to help patients learn self-management skills to prevent and control CKD. KCQEA also calls for providing educational sessions to stage 4 CKD Medicare beneficiaries to provide options on how to slow the progression of the disease. The education of patients and providers about CKD will allow for earlier identification and subsequent intervention with well-established clinical practice guidelines. These guidelines are intended to slow the progression of kidney disease or, as is the case with the Renal Physicians Association guideline for the appropriate use of renal replacement therapy, guide the transition of patients in stage 4 to ESRD.
2. Establish a payment update mechanism through a 3-year continuous quality development initiative that would reward quality improvements and attainment of clinical and quality of life targets. It is critical to recognize that the incentive payments come from the increased monies made available through the increased annual update. Although dialysis providers have been on the forefront of publishing quality outcomes, the kidney care community agrees that facilities, providers, and physicians should report quality data based on clinical and quality of life measures developed in consultation with the kidney care community. Dialysis providers and physicians should have the opportunity to receive quality bonus payments based on the attainment of benchmarks and maintenance of quality outcomes, which would be tied to a portion of an annual update. Because the ESRD composite rate is the only Medicare prospective payment system without an annual update mechanism to adjust for changes in input prices and inflation, Congress should provide an update to dialysis facilities for the duration of the continuous quality improvement initiative, thereby linking an annual update to clinical performance.
3. The quality payments would be funded through a portion of an annual inflation update. Currently, the Medicare ESRD program is the only prospective payment system without an annual update mechanism to account for inflation and other increases in costs. This legislation would provide for updates for 3 years and link a portion of that update to quality improvement and attainment.
4. In addition, the bill improves coverage for home dialysis therapy by requiring the