Kidney Watch 2015

The Future of the Sustainable Growth Rate: A Pay-For Story

By Mark Lukaszewski

In 2014, Congress made major gains toward finally repealing the broken sustainable growth rate (SGR). But, as of press time, Congress had failed to get legislation to repeal SGR over the line, meaning that physicians will again face pay cuts—and the hope of repeal—in 2015.

What is SGR?

In an attempt to control Medicare spending on physicians' fees, Congress enacted the SGR formula in 1997. Although it has called for dramatic reductions in payments over the past decade, each year Congress has temporarily overridden the cuts and kept the SGR in place. According to the formula, if no changes are made, physicians' fees are set to be reduced by 21.2 percent on March 31, 2015, which would have a devastating, irrevocable effect on the Medicare system.

Is Congress the problem?

It would be natural to assume that the usual health care political games and congressional hold-ups that we have seen in the past are responsible for preventing SGR reform, but for once that assumption would be wrong. Legislation to replace SGR gained tremendous bipartisan, bicameral support in the House and the Senate in this past congressional session. With agreement on both sides of the aisle that the SGR needs to go, and with consensus on legislation to accomplish that goal, why are we still stuck with the current SGR?

Where is the issue?

The answer is the up-front cost of replacing the SGR. The Congressional Budget Office, which is responsible for providing Congress with cost estimates for legislation, indicated that repealing SGR would cost roughly $150 billion. Therefore, offsets are needed to defray the cost of permanently replacing the SGR. For a replacement to be put into place, Congress has to either cut money from other programs or come up with a new funding source.

Future of SGR in the 114th Congress

With such a big price tag and few ideas for pay-fors, SGR legislation is highly unlikely to pass in 2015. Given the recent election results, the question is whether the upcoming Republican-controlled Congress can find a suitable pay-for to accomplish comprehensive SGR repeal legislation. It is almost certain that *something* will be

on the chopping block to cover the cost of the legislation. However, if the only pay-for Congress offers is defunding the Affordable Care Act (Obamacare), the bill has little to no chance of becoming law, and it would be vetoed as soon as it hits the president's desk.

The American Society of Nephrology (ASN) believes that repealing SGR is not a partisan issue and will continue to work in 2015 with the relevant congressional committees and the broader medical community to build on the gains made. Stay tuned to *ASN Kidney News* and to e-mail communications from ASN to learn how you can get involved in advocating for SGR replacement.

Disparities in Kidney Care: Geography, Race, and Perceived Racial Discrimination Will Garner Continued Attention

Patients' access to specialized care before kidney failure develops varies significantly across the United States and among different racial groups. And perceived racial discrimination may have negative effects on kidney function.

Pre-ESRD nephrology care is crucial for optimizing the health of patients with this condition. How the United States and global kidney community ensure such care for the millions of people with kidney disease is crucial to stemming the disease's growing prevalence.

One approach is to look at the adequacy of care patients receive in different parts of the country and then examine the reasons for discrepancies in care.

Brendan Lovasik of the Emory University School of Medicine and his colleagues are taking this approach. They recently looked to see whether patients across the country are receiving adequate access to kidney care.

Using a comprehensive national data set and advanced statistical modeling techniques, the researchers identified several geographic areas in the United States with significantly low rates of pre-ESRD kidney care. Dialysis facilities in the lowest quintile of pre-ESRD nephrology care were geographically clustered in several distinct areas, including San Francisco, Los Angeles, Chicago, Miami, and Baltimore, and along the corridors of the Mississippi and Ohio Rivers. Also, facilities in the lowest quintile of pre-ESRD nephrology care were 1.88 times more likely to be located in inner cities compared with those in the highest quintile. The lowest quintile facilities were 1.96 times more likely to be in high-poverty neighborhoods. The proportion of racial minorities within a neighborhood was not associated with pre-ESRD kidney care rates.

"Improved outcomes among the chronic kidney disease population depend on earlier identification of patients with kidney disease who may require ESRD treatment, as well as greater awareness of patient morbidity and mortality, quality of life, and the financial benefits of kidney transplantation over dialysis," said Lovasik. "Our findings may help policy makers target low–pre-ESRD facilities and regions to improve access to specialty care with interventions and specific pilot programs aimed at improving patient outcomes."

In another recent study, Guofen Yan, PhD, of the University of Virginia, and her team looked at county-level disparities in pre-ESRD care. Their analysis of black–white comparisons included 1270 counties that had 5 or more patients of each race, resulting in 346,368 patients. Their Hispanic–white analysis included 613 counties with five or more patients of each race, resulting in 224,286 patients.

The researchers found that although disparities were more likely in certain geographic areas, they existed in diverse locations and in most counties of the United States. The overall percentage of patients who received care from a nephrologist at least 12 months before ESRD was lowest in Hispanics (20.0 percent), intermediate in blacks (23.8 percent), and highest in whites (30.0 percent). Black patients' likelihood of receiving care from a nephrologist was 10 percent to 54 percent lower than that of whites in approximately two-thirds of the counties. Hispanic patients' likelihood of receiving a nephrologist's care was 10 percent to 48 percent lower than that of whites in nearly all of the counties. Counties with larger disparities tended to be of lower socioeconomic status and to have fewer health care resources, and they were more likely to be located in the

Continued on page 6