

## 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 re-

form, 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*



## Disparities in Kidney Care

*Continued from page 5s*

South and within large metropolitan areas. “Our findings indicate that efforts to improve pre-ESRD care should be implemented nationally rather than regionally,” said Yan.

Psychosocial stressors and their role in progression of kidney disease will also garner more attention in 2015.

Recent research is already leading the way.

To look at the relationship between perceived racial discrimination and kidney function decline, researchers led by Deidra Crews, MD, FASN, of Johns Hopkins University School of Medicine, studied a biracial urban population of adults with preserved kidney function in Baltimore, MD. The team assessed whether perceived racial discrimination, as measured through an adaptation of the Experience of Racial Discrimination questionnaire, was associated with kidney function decline over five years of follow-up in the Healthy Aging in Neighborhoods of Diversity across the

Life Span study. A total of 1574 participants (630 whites and 944 African Americans) aged 30 to 64 years at baseline were included.

Twenty percent of individuals in the study perceived themselves to have been discriminated against “a lot” because of their race. Such individuals were more likely to be African American and to have a higher educational background, but they were more likely to be living in poverty than those who reported little to no perceived discrimination. Additionally, those who perceived “a lot” of discrimination had higher systolic blood pressure but a lower prevalence of diabetes than did those perceiving little to no discrimination.

Perceived racial discrimination—regardless of sociodemographic, lifestyle, and health factors—was linked with greater kidney function decline over five years of follow-up. When analyzed by race and sex, the link between perceived racial discrimination and kidney function decline remained only among African American women. Systolic blood pressure was responsible for 15 percent of this association.

“Perceived racial discrimination may contribute to disparities in kidney disease and might exert its effect on risk of kidney function decline through stress-related pathways,” said Crews. “This study can serve as a basis for future studies focusing on psychosocial stressors and their potential contributions to the initiation and progression of kidney disease.”

The two studies were presented at Kidney Week 2014. ●

### Studies

Geographic Determinants of Low Pre-ESRD Nephrology Care in the United States (Abstract SA-PO849).

Racial and Ethnic Differences in Pre-ESRD Care in U.S. Counties (Abstract SA-PO857).

Association of Perceived Racial Discrimination and Kidney Function Decline among African Americans and Whites (Abstract SA-PO856).

Disclosure information is available at <http://www.asn-online.org/education/kidneyweek/2014/program-faculty.aspx>.

## Prospects for NIH and Kidney Research Funding in the New Congress

By Grant Olan

The dust is still settling from the election of November 4, 2014, when Republicans gained control of both chambers of Congress. Whether a Republican Congress and a Democratic administration can work together to address the many domestic and foreign challenges confronting the country today is one of the biggest questions as we head into 2015.

One thing most Democrats and Republicans agree on, though, is that medical research is one of the smartest investments the United States can make. Funding for the National Institutes of Health (NIH), the global leader in medical research, creates jobs, drives the economy, and most importantly leads to new discoveries that improve patient care. Unfortunately, sustained budget cuts since 2010 are jeopardizing this country’s research enterprise.

Despite the general support for medical research among Republicans and Democrats, their hands are tied by the Budget Control Act of 2011 and the Bipartisan Budget Act of 2013, which imposed strict budget caps as part of efforts to curb the federal deficit and debt. Unless Congress raises

the caps or rescinds those laws—and given the makeup of the new Congress that starts on January 3, 2015, it is hard to imagine a scenario for that happening—then additional funding for the NIH would come at the cost of funding for other federal programs.

Moreover, the United States is projected to hit the debt ceiling (the total amount of debt this country can accumulate) again in April 2015, further complicating efforts to increase federal spending. Republicans will likely call for more budget cuts in exchange for raising the debt ceiling. Despite the challenging times, some bold leaders have come forward to call for doubling the NIH’s budget.

Sen. Roy Blunt (R-MO) recently announced that it is one of his priorities. In October 2013, Sen. Elizabeth Warren (D-MA) said that those who say we cannot afford to double investments for the NIH “. . . are wrong. Research creates economic growth. It reduces health care costs. It creates a better life for our people. And yet, the success rate for NIH grants has dropped by nearly 50 percent over the past 10 years. That makes no sense. There is good work to be done—work to save

lives and work to boost our economy. We cannot afford not to increase our investments in medical research.”

The American Society of Nephrology (ASN) applauds the leadership of Senators Blunt and Warren and will work with them and the new majority in the Senate to advance funding for the NIH and other research agencies in 2015. The society will also continue working with the research community to implement the society’s aggressive new Research Strategic Plan to bolster support for more kidney research funding.

Two research efforts that ASN supports and helped to shape are making their way through Congress: a comprehensive kidney care bill advanced by Kidney Care Partners—a broad coalition of the kidney community, including ASN, dedicated to advancing patient care—and the 21st Century Cures initiative to identify steps for accelerating the pace of cures and medical breakthroughs in the United States.

Stay tuned: the ASN will need your help calling on Congress to urge support for research funding during the spring budget season. ●

## ESRD Seamless Care Organizations: Debuting Soon

By Rachel Meyer

Nearly two years after the Centers for Medicare and Medicaid Innovation (CMMI) announced the first-ever disease-specific innovation model, the first performance period of the ESRD Seamless Care Organizations (ESCO) program is slated to begin in January 2015. Large Dialysis Organization (LDO)-based ESCOs will be the first to participate in the program, followed by ESCOs operated by Small Dialysis Organizations (SDOs) in July 2015. Speaking at a meeting of the Council of Medical Subspecialty Societies in late November 2014, CMMI Seamless Care Models Group Director Hoangmai Phan, MD, confirmed the early 2015 launch date.

But as 2014 wound to a close, unanswered questions about the program remained—even after two major CMMI overhauls to the design and operation of the program as well as several delays in the program start date.

As of press time, CMMI had not yet finalized the quality measures upon which the dialysis providers and nephrology practices that join together will be judged. CMMI engaged a contractor to convene a technical expert panel (TEP) to select quality measures, but to date contractor IMPAQ states that “CMS is conducting further research on the feasibility, usability, and technical considerations of the following proposed draft measurement set” TEP developed.

Because CMMI has been adamant that the ESCO program goes beyond kidney care to providing comprehensive care, it is highly likely that quality measures will expand beyond familiar quality improvement metrics. However, it remains to be seen whether the measures selected will have been tested and verified in the ESRD patient population—and whether the performance criteria will reflect the

unique ESRD patient population.

The Innovation Center has been tight-lipped regarding how many applications it received for the ESCO program, but rumors suggest that approximately 15 LDO ESCO applications were submitted. CMMI convened two reviewer panels to assess applications, one in July for LDO ESCOs and one in September for SDO ESCOs, but it has not released any public information about the panels or next steps for the applicants. Of course, CMMI approval of an application does not bind the applicants to launching an ESCO, so these numbers may not accurately reflect the program’s chances of success. Much will depend on how CMMI decides on some of the program’s yet-unanswered questions.

The year 2015 will be the proving ground for this new program, which will likely also set the tone for future disease-specific innovation models. ●