ASN LEADING THE FIGHT AGAINST KIDNEY DISEASE

KidneyNews

December 2012 | Vol. 4, Number 12

Safety Net Health Care Systems Can Deliver Equitable Care and Good Hypertension Outcomes

By Kurtis Pivert

Patients with CKD who rely on safety net health care systems may receive more equitable and effective care, concludes a study that compared one such system, the Community Health Network San Francisco (CHNSF), with a representative sample of the U.S. population.

Delphine Tuot, MDCM, of the University of California, San Francisco, and her colleagues observed that patients with mild CKD receiving care from CHNSF demonstrated better control of hypertension among racial and ethnic minorities than a similar cohort from the National Health Examination and Nutrition Survey (NHANES) (1). Yet despite these encouraging results, Tuot also reported that African Americans have an increased risk for uncontrolled hypertension when compared to whites, even in the public health care setting. Tuot spoke at Kidney Week 2012 in San Diego.

Although the study shows the potential of systems such as CHNSF to act as frontline agents to reduce disparities of care for a population that may have higher risks for developing CKD and progression to ESRD, it also raises the question of how their success could be translated to improve hypertension control among at-risk minorities with more severe CKD.

Research has shown that racial and ethnic minorities have a higher risk for developing CKD and progressing to ESRD than whites, yet the reasons behind this are unclear. Most likely, this may be due to a combination of factors, and uncontrolled hypertension could be a major contributor to the accelerated and early rate of disease progression that these at-risk populations exhibit.

Efrain Reisin, MD, FACP, FASN, professor of medicine and chief of the section of nephrology and hypertension at the Louisiana State University Health Science Center, New Orleans, who was not involved in the study, said there are congenital, behavioral, and health access factors that contribute to higher rates of uncontrolled hypertension among minorities.

"African Americans, with or without CKD, have a higher rate of associated conditions than Caucasians (e.g., diabetes in men and diabetes and obesity in women)," he said. They also have some congenital

Continued on page 2

Health Reform Moves Forward

President Obama's re-election ensures that the Patient Protection and Affordable Care Act (ACA) will continue to move forward.

The election result, following the Supreme Court decision upholding its constitutionality earlier this year, apparently removes the final obstacle to a host of provisions taking effect in just over a year—including new patient protections, marketplaces for buying insurance, and taxes and fees to pay for the law (see sidebar).

Supporters predict that Obamacare—a term coined by opponents as a pejorative but now embraced by its namesake—will grow in popularity once these provisions come into force. But the law still faces opposition and considerable uncertainty about what the next few years will bring.

The ACA's main goal is to increase the number of Americans with health insurance coverage. According to the latest estimates from the nonpartisan Congressional Budget Office, the ACA will increase the number of people below Medicare age with health insurance coverage by 14 million in 2014 and by 29 to 30 million by 2022. That growth represents an increase from today's 82% to 92% of the nonelderly population, but is down from estimates made before the June Supreme Court decision that upheld most of the law's provisions, but gave states the power to opt out of the planned expansion of Medicaid.

The act's overarching goals, if not its specifics, have been supported by a wide range of medical organizations. A greater portion of the population having insurance, which implies a greater chance for early treatment of developing conditions, should benefit patients and reduce costs, said Thomas Hostetter, MD, chair of

Continued on page 2

Inside

Safety Net

Continued from page 1

characteristics that increase the incidence of hypertension, including lower plasma renin activity (PRA) levels with expansion of fluid volume, and higher prevalence of salt-dependent hypertension. Other barriers to controlling BP in African Americans include low access to medical care and poor adherence to treatment. Also, more populations of African Americans live in communities that lack safe environments for walking or exercising and less neighborhood grocery stores that may offer easy access to a fresh and healthy food supply."

Because public health care delivery systems act as safety nets and deliver care for vulnerable populations, including minorities, they have the potential to reduce disparities and improve the outcomes of those who are at highest risk for kidney disease. To assess their performance in BP control, Tuot compared the prevalence and odds of uncontrolled hypertension among patients with CKD in CHNSF—an integrated health care delivery system that cares for San Francisco's uninsured and publically insured residents—with national estimates using data from NHANES.

A total of 6681 patients with CKD who received care at CHNSF between 2010 and 2012 and 3108 NHANES participants with CKD who saw a physician between 2003 and 2010 were included in the study. Although the cohorts differed in age, racial composition, number of non-English speakers, and uninsured individuals, both had similar rates of diabetes. Diagnosis of CKD was confirmed by an eGFR 15–59 mL/min/1.73 m^2 or a dipstick albuminuria test result >30 mg/g, with uncontrolled hypertension defined as a mean systolic BP >140 mm Hg or a mean diastolic BP >90 mm Hg. Prevalence of uncontrolled BP in the both cohorts was calculated, as well as odds ratios for uncontrolled hypertension among racial minorities as compared to whites with CKD, controlling for age, gender, insurance status, and presence of diabetes.

In mild CKD (stages 1 and 2), African Americans in the CHNSF cohort had an 8 percent higher odds for uncontrolled hypertension compared with whites. This contrasted strongly with the results from NHANES, in which odds for uncontrolled BP were 153 percent higher among African Americans compared to whites. In CKD stages 3 and 4, the odds for uncontrolled BP in the CHNSF were 11 percent higher for African Americans and 6 percent higher for Hispanics versus whites, compared with a 27 percent higher odds but a 43 percent lower odds for those in NHANES, respectively. Overall adjusted rates of uncontrolled hypertension were higher in the CHNSF cohort compared to NHANES (25.42 percent versus 21.72 percent). When stratified by severity of CKD, rates remained higher for CHNSF in stage 3 and 4 CKD (28.06 percent versus 23.08 percent) but were lower for stage 1 and 2 CKD (18.00 percent versus 22.13 percent) compared to NHANES.

The results revealed that "differences in BP control among patients with CKD of different races/ethnicities were smaller in the CHNSF compared to the national average, and that CHNSF appears to provide more equitable care to patients with CKD," said Tuot.

Were the higher rates of uncontrolled hypertension among African Americans unexpected? Reisin didn't think so. "They have a higher rate of hypertension and resistant hypertension than Caucasians due to genetic and behavioral factors. In fact, previous reports from the VA Health Care sites have also shown a lower rate of hypertension control in African Americans when compared with Caucasian subjects, despite the fact that in the VA system both groups have the same access to medications and health care."

Reisin added that the better performance of CHNSF in managing hypertension in CKD 1 and 2 was also unsurprising given that "previous studies have proven that effectiveness of care may vary among providers. Some health providers may be slow to follow recommended treatment guidelines, or may not have all the resources needed to treat low-income populations or those with special needs, conditions that make it more difficult to control BP."

The higher rates of uncontrolled hypertension in patients with stage 3 and 4 CKD reported in this study are indicative of the difficulties in managing this population. "According to previous publications, the rate of resistant hypertension increases from 5 percent in general practice to 50 percent or higher in nephrology clinics that treat African Americans or Caucasian CKD patients. The decrease in GFR increases BP and impairs the maintenance of sodium balance and body fluid homeostasis," he said. "Also, the presence of associated diseases like diabetes, obesity, and sleep apnea are very important factors that increase the rate of resistant hypertension in more advanced CKD stages."

The work demonstrates that "public health delivery systems, similar to the CHNSF, may provide more equitable care for patients with CKD than national averages and do a good job of controlling BP in patients with early CKD, despite caring for a population with high rates of poverty, limited health literacy, and non-English speakers," Tuot said. Yet she noted more research is needed to better understand why results differed in patients with mild CKD compared to patients with moderate/severe CKD. "This may reflect challenges in timely and appropriate care for those with more severe disease, including access to nephrologists, but at this point, we do not know," she said. "But I would like to challenge our community to translate these results in mild stages of CKD to improve care for our patients with more moderate and severe stages of the disease."

Reisin agreed that more research is needed to "further investigate the pathogenesis of resistant hypertension in African Americans, Hispanics, and other minority communities. In addition, clinical studies should include higher minority participation in the enrolled population to facilitate the assessment of safety and efficacy of different therapeutic approaches in these subjects."

Reference

1. Tuot DS, et al. Blood pressure control among CKD patients in a public health system. (Abstract)

Health Reform

Continued from page 1

ASN's public policy board.

"If we can have some 90 percent of the population covered, hopefully that would mean that people with chronic kidney disease could be treated earlier and more effectively, and their need for dialysis or transplantation prevented or forestalled," Hostetter said.

One of the major ways that the ACA will increase coverage is by expanding Medicaid eligibility to include those with incomes up to 133% of the federal poverty line, for a cutoff of about $29,000 for a family of four. The Supreme Court dealt this effort a blow with its unexpected ruling that states could decide whether or not they wanted to participate in the expanded program.

As of mid-November, governors of at least seven states had declared that they would not expand Medicaid (and these states generally have a higher proportion of poor and uninsured people).

States could change their positions as time goes on, as they did when Medicaid was introduced in 1965, according to John Poelman, senior director at Leavitt Partners, a nonpartisan health care consulting group established by Mike Leavitt, a former Utah governor, Bush administration official, and head of the transition team for the Romney campaign. Poelman said that most states had implemented Medicaid within five years, but the last state, Arizona, did not do so until 1982.

Tim Jost, JD, a law professor at Washington and Lee University with an extensive background in health care policy, said that over time states will find it hard to turn down the federal dollars. The federal government pays about 60% of the costs of the current Medicaid program. In the expanded version, the federal government will cover 100% of the cost for the newly eligible people in 2014 and 2015, then pay a share that declines to 90% from 2020 on. "I think when they look at it hard, they're going to see there are so many reasons to do it and no reason not to," Jost said.

For the moment though, many governors not only oppose Obamacare, but are suspicious about the federal government's ability to uphold its end of the bargain given its budget situation, and say they do not want to contribute to larger deficits.

State officials are likely to feel pressure from their local medical communities because, in the expectation of greater insurance coverage resulting in fewer uninsured patients showing up at their doors, hospitals acquiesced to cuts in Medicare and disproportionate share payments in the ACA.

"The hospital cuts in the ACA were hopefully to be balanced out by an expansion of insurance," said Atul Grover, MD, PhD, chief public policy officer of the Association of American Medical Colleges. "If states fail to follow through on the Medicaid expansion, that could lead to further, severe losses for many of our safety-net teaching hospitals that are already barely breaking even."

Softening opposition?

Although voters in several states took symbolic steps to express opposition to the law, there is evidence that opposition is softening. Alabama, Montana, and Wyoming passed referenda aimed at nullifying the individual mandate to buy insurance or pay a fee, but none of these measures can have any effect because federal law supercedes them. A similar amendment in Florida failed. Missouri passed a law that forbids the governor from setting up a health insurance exchange by executive order.

But a Kaiser Family Foundation poll taken after the election found that the proportion of Americans who want to see the law repealed has dropped to a new low of 33%, the lowest number since the legislation passed and a 7% drop since August.

State exchanges

Florida Gov. Rick Scott, one of the most vocal critics of the ACA, told the Associated Press that given the election results he is willing to consider setting up a state-run insurance exchange he had previously ruled out. These exchanges are designed to be online marketplaces where individuals and small businesses can shop for insurance by easily comparing policies. The exchanges will certify plans as meeting standardized essential benefit packages to make it easier for buyers to know what they are being offered, and provide information to help consumers understand the options. Because they will also streamline the process for enrolling in Medicaid and the Children's Health Insurance Program (CHIP), they could lead to an increase in Medicaid rolls if consumers shopping for a policy learn of their eligibility for Medicaid.

States have the option of setting up their own exchange, participating in a state-federal partnership, or leaving it to the federal government to run an exchange in their state. At least in part in response to a letter from the Republican Governors Association asking the Obama administration to push back the date until it had answered more questions from governors and promulgated final regulations, the administration extended the deadline for states to decide until Dec. 14. As of mid-November, 16 states and the District of Columbia had opted to set up their own exchanges, six had opted for a partnership, and 19 had opted for a federal exchange.

But Laura Summers of Leavitt Partners said that states are running into difficulties because they are encountering a daunting number of rules and regulations, yet many requirements have still not been released or finalized. "States are having to make these decisions with a lot of uncertainty, and so they don't really know yet whether it would be beneficial," she said.

Republican Virginia Gov. Bob McDonnell made this point the day after the election when he announced that his state would not expand its Medicaid program or establish a state-sponsored insurance exchange. "I don't want to buy a pig in a poke for the taxpayers of Virginia," he said at a news conference, contending that the administration has not provided enough

information. But McDonnell left the door open to setting up an exchange at a later date.

The choice for states' rights advocates—to accede to the directives of a federal law they object to by setting up an exchange or cede this activity to the federal government—can be a sticky one. For example, Colorado established a bipartisan board to set up its exchange. One of the sponsors of the enabling legislation was Republican state representative Amy Stephens. She told National Public Radio that she opposes Obamacare, but: "I believe Colorado knows how to do health better than the federal government."

The exchanges are due to be operating by Oct. 1, 2013, for coverage starting Jan. 1, 2014, and many observers doubt that the administration will be able to keep to the schedule, given the complaints about the lack of guidance thus far. But Michael Hash, director of the office overseeing the efforts, said that his office has the contractors in place and is on track to meet the deadlines.

Kidney care and the ACA

Kidney care is one area that illustrates the uncertainty in the essential benefit packages to be offered in policies on the exchanges. The packages will be defined mostly by each state based on their customary policies already available, but will have to meet standards for deductibles and out-of-pocket costs. Important unresolved issues include the availability of immunosuppressive drug coverage for kidney transplant recipients, the interface between exchange-based insurance coverage and Medicare's end stage renal disease program, and the treatment of living organ donors, according to Dolph Chianchiano, JD, MBA, health policy adviser to the National Kidney Foundation. Chianchiano said that federal regulators may be allowing states the latitude to design their own approaches to these issues. The National Kidney Foundation and groups like the American Medical Association have urged that the essential benefits package be modeled on Medicare Part D, which includes anti-rejection medications on its list of protected drug classes, but federal regulators have yet to give a specific response on the issue.

One way that Republican House of Representatives opponents of the law have threatened to block implementation is through the power of the purse, by withholding appropriations. How effective this tactic could be is a subject of debate, but the need to set up more federal exchanges because so many states are refusing to set up their own could require increased federal expenditures.

Michael Cannon of the libertarian Cato Institute has encouraged this approach, blogging that "Congress authorized no funds for federal 'fallback' exchanges. So Washington may not be able to impose exchanges on states at all." Another potential area they might look to cut could be the subsidies for buying insurance.

"Restricting funding for implementation is a lever that still exists," Leavitt Partners' Poelman said. "But all funding of the government . . . requires both chambers to agree. The House will certainly move to restrict funding for implementing the Affordable Care Act but that will be negotiated as part of a larger funding package. When it comes down to making a final deal there will have to be compromises on both sides. It is quite likely that the administration won't get all the money it wants to implement the law but the overall enactment won't be halted."

With the fiscal cliff approaching, negotiations could address almost any aspect of the budget. "The House and the Senate and the president are going to have to get together on a whole bunch of financial issues," said Washington and Lee's Jost. "And the Republicans have already said they will be gunning for the Affordable Care Act through the appropriations process. Having fought this hard for the Affordable Care Act, the president is going to fight pretty hard to keep the funding there, and frankly, there aren't a lot of places to cut [in the ACA]."

Although the election settled some questions, the coming years will still be full of uncertainty and some dislocations. Some employees may find it easier to change jobs because of the prohibition of exclusions based on pre-existing conditions. Those who already have coverage should be largely unaffected except for greater protections, although the possibility exists that some employers may drop coverage.

A U.S. Government Accountability Office analysis of several studies found that microsimulation studies predicted little change in employer-sponsored coverage, but surveys of employers varied widely in results. Of course, these projections come in a context in which for the past decade the share of employers offering coverage has declined and employees have been asked to pay a larger share of costs. Massachusetts has seen a small increase in employer coverage since its plan was enacted, Jost said.

Another concern is whether the health care system will be able to cope with an influx of new patients, especially with shortfalls of providers already on the horizon. A recent study in the *Annals of Family Practice* estimated a need for 52,000 more primary care doctors by 2025. But it said that most of these are necessitated by population growth and the aging of the population, with only 15% chalked up to the expansion of coverage from the ACA.

Massachusetts has shown creative ways of coping with the greater demand, with increased reliance on use of physician's assistants and nurse practitioners, according to Grover of the Association of American Medical Colleges.

Research benefits

From the point of view of the kidney community, the ACA moving forward means continuity for a pair of research centers the act has already established. The Patient-Centered Outcomes Research Institute is a nonprofit with the mission of funding comparative effectiveness research—research that can be particularly difficult to find sponsors for. ASN's Hostetter said that nephrology is a discipline that could particularly benefit from this research. Another new agency, the Center for Medicare and Medicaid Innovation, is charged with finding new payment and delivery methods that improve care while lowering costs. As part of this effort, Medicare has begun contracting with accountable care organizations (ACOs)—team-based efforts in which doctors and other providers coordinate care for Medicare patients. Medicare has contracted with 153 ACOs so far, but expects that number to double to 300 in January. ASN has weighed in with recommendations on how ACOs could provide better integrated care in kidney disease, since it is particularly suited to a team approach.

The ACA promises big changes, so the debate over it is sure to continue, but many in the kidney community say they are seeing benefits and anticipating more.

Key Milestones in Implementation of the Affordable Care Act

The Affordable Care Act is designed to increase protections for patients, increase the number of people covered by health insurance, and require more people to contribute dollars to the health-care coverage pool. Its approach is based on some trade-offs: Because more people are required to buy insurance, insurance companies can drop pre-existing conditions requirements. Because hospitals will treat fewer uninsured patients, it reduces some government payments to hospitals.

One of the most important dates in the implementation is Jan. 1, 2014, still a little more than a year away, when many provisions take effect. Although the act was passed in 2010, implementation was staged to give consumers, insurance companies, state governments, and the federal government time to adjust to the changes. Here is a summary of some of the main provisions.

Requirements already in place

The law includes a "patient's bill of rights" that ends lifetime limits on coverage, restricts the conditions under which insurers can cancel coverage, requires plans to allow parents to include any children under 26, and ends pre-existing condition exclusions for children under 19, among other things. It created a special insurance pool for patients with pre-existing conditions.

Starting in 2010, health plans are required to cover preventive services such as mammograms and colonoscopies without charging a deductible, co-pay, or co-insurance.

Protections scheduled to start Jan. 1, 2014

- Eliminates pre-existing conditions exclusions: Insurance companies cannot refuse to sell coverage because of an individual's pre-existing conditions or to exclude pre-existing conditions from coverage.
- Prohibits insurance companies from charging higher rates due to gender or health status.
- Eliminates annual limits on insurance coverage.
- Requires insurance to cover patients who participate in clinical trials.
- Requires efficient administration by insurers: At least 85% of premium dollars collected for large employer plans and 80% for individuals and small employers must be spent on health care services and quality improvement. Any amount that doesn't meet these goals must be rebated to consumers.

Paying for expanded coverage

Starting Jan. 1, 2014, most individuals who can afford it must either buy health insurance or pay a fee designed to help offset the costs of caring for the uninsured. The fee is $95 or 1% of income in 2014, $325 or 2% of income in 2015, and $695 or 2.5% of income in 2016 (but no more than the cost of an average basic plan). These fees are generally much less than the cost of insurance, but the ACA is modeled on the Massachusetts model, where similar fees have been effective in getting people to enroll in insurance plans.

To make insurance affordable, federal tax credits will be available to people with incomes up to four times the federal poverty line (400 percent of the poverty level is about $43,000 for an individual and $88,000 for a family of four).

Individuals will be able to shop for policies at insurance exchanges.

Incentives and requirements for businesses

Small businesses with fewer than 25 workers will receive tax credits for up to 50% of the premium cost, and may find coverage more easily through the exchanges.

Employers with 50 or more full-time employees that do not offer coverage or offer coverage deemed unaffordable will incur penalties. Employers with more than 200 employees must automatically enroll new full-time employees in coverage.

New taxes and fees

The Congressional Budget Office projects that the ACA's net effect will be to lower the federal deficit because it includes revenues from new taxes, fees, and limits on deductions. For example, it lifts the cap on Medicare taxes paid by those with high incomes and taxes so-called "Cadillac" health insurance policies. It also institutes new fees on insurers, drug makers, and medical device companies.