

Effect of the 2012 Election on Health Policy Issues for the Nephrologist

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Predictions are dangerous, especially those about the future.

—Yogi Berra

Elections have consequences. On November 6, 2012, President Barack Obama won an overwhelming Electoral College victory and a closer popular vote to give him a second term as president. The United States will continue to have a divided government because the Senate remains in the control of the Democrats and the House continues to be controlled by the Republicans. How this will affect our economy, foreign policy, or defense policy is uncertain, but what is clear is that the Affordable Care Act (ACA) will continue to be implemented because the Republicans do not have the power to override a presidential veto to derail it. How will nephrology and nephrologists be affected by the implementation of the ACA over the next 4 years? Respectful of the advice given by one of the country's most famous "philosophers," what follows are my thoughts as to what we might expect and plan for.

Organization of Care-Payment for Care

Whereas the ACA covers all Americans, the government has an important role to play through the Medicare program and to a lesser extent the Medicaid program. Medicare is the primary vehicle that the government will use to affect the organization of care. The mantra of the Centers for Medicare and Medicaid Services (CMS) is the "triple aim" attributed to its former administrator Dr. Don Berwick, namely better population health, better individual patient care, and meaningful cost savings. Any new program or improvements to existing programs will be judged against those aims. However, it has been my experience in Washington that regardless of the administration or ideology, budget trumps policy except in matters of national security. The ACA looks to accountable care organizations (ACOs) as a means to achieve the triple aim. The theory is that integrated care is less expensive and provides better outcomes. The Administration has, correctly in my view, chosen to organize ACOs around primary care in a shared savings model (this article will not delve into the subtleties of the various proposed models), but this should not discourage nephrologists from

participating as subcontractors. Indeed, if I were the Chief Executive Officer of an ACO, I would seek to "de-risk" or subcontract the care of my ESRD patients to organizations that had experience taking care of those patients.

Within the CMS, the Center for Medicare and Medicaid Innovation (CMMI) is charged with developing new ways to organize and pay for care. The renal community has been meeting with the CMMI to develop an integrated care program for at least ESRD and ideally both CKD and ESRD, (*i.e.*, predialysis and dialysis). I would expect that there will be pilot programs sponsored by the CMMI over the next few years.

Currently, dialysis is paid for by Medicare using a prospective payment or "bundle." In 2014, the bundle will include oral drugs used for ESRD that do not have intravenous equivalents such as phosphate binders and cinacalcet. This means that individual dialysis units will have to provide these drugs to their patients either by dispensing them or arranging for a third party to provide them. Although this is not a problem for large dialysis groups, it may be for smaller ones and will no doubt accelerate the consolidation of the dialysis industry.

The bundle, however, is an unsustainable payment model for the long term. The major cost driver of ESRD care is hospitalization. As most nephrologists know, hospital care is paid for by Medicare Part A (the Trust Fund), whereas dialysis is paid for by Part B (premiums and general revenues). Most of the quality-of-care improvements in the dialysis unit lead to decreased hospitalizations, yet neither the nephrologist nor the facility share in those savings under the current system. Therefore, if we are to continue to achieve efficiencies in care, we should share in the savings that result. This is why an integrated care model encompassing the totality of care is the rational choice to organize ESRD care. In addition, nephrologists know that good predialysis care as it relates to vascular access, anemia management, and bone and mineral metabolism makes the transition to dialysis more cost-effective. Including predialysis (however this is defined) care in an integrated care model would certainly meet the triple aim criteria better than any of the options currently being discussed.

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Finally, given the financial incentives in the bundle, I am optimistic that we will finally see a growth in home care, both home hemodialysis and peritoneal dialysis. For appropriate patients, home care achieves the triple aim goals.

Coverage and Its Consequences

The major goal of the ACA is to provide affordable health care insurance to all American citizens and legal residents (undocumented aliens do not qualify). As a result, most Americans will have at least a policy with a minimum benefit package (to be defined later). The Supreme Court upheld this provision in June 2012, declaring that the penalty for not purchasing insurance was a tax and therefore was constitutional. Therefore, we can expect to see more people visiting their physicians and presumably more people being identified as having CKD and ideally being referred to a nephrologist. The fly in the ointment, however, is that there may not be enough nephrologists to see them. The 2012 match that was just completed showed that 23% of programs were unfilled and 11% of positions went unfilled. This was the worst of all medical subspecialties. In addition, of the matched applicants, 51% were foreign and <1 in 5 new fellows were American graduates of US medical schools (1). Clearly, nephrology is not a highly desired subspecialty in the United States. This suggests that the nephrology workforce may, in the coming years, be unable to meet the demand of the expanded covered population. As a result, we should expect to see the development of new delivery models that rely more on nonphysician providers. Whether and how this will affect the quality of care provided to our patients remains to be seen; however, at the very least, nephrologists, patients, and payers (including the government) will undoubtedly want and demand better quality-of-care measures.

In its June 2012 decision, the Supreme Court found that the Medicaid expansion provision of the ACA was invalid. Now each state will have to decide whether to expand Medicaid to 133% of the poverty level. If they do, the federal government will pay 100% of the cost for 2 years and 90% thereafter. Shortly after the election, the Administration, in response to several governors, stated that this must be an “all or none” decision as the governors inquired as to whether they could make gradual increases to their programs. The “arithmetic” for this decision plays out differently for each state based on its current program, its fiscal health, and its willingness to and ability to pay the 10% in the future. There is also some concern that future Congresses may alter the payment percentages in response to a federal fiscal crisis. On the other side, all states are being pressured by providers to accept the “deal” because it appears to provide them with a more secure revenue source and reduces the burden that they may face treating these uninsured people. The outcome is far from clear although it is unlikely that all states will participate.

Although it is not tied directly to the election, a major unfinished piece of business for the current Congress is the Comprehensive Immunosuppressive Drug Coverage for Kidney Transplant Patients Act of 2011. This legislation introduced in both houses (H.R. 2969 and S.1454) would remove the 3-year restriction on coverage of immunosuppressive

drugs after transplantation. If it is not passed by the end of 2012, it will die as it has in several previous Congresses. To nephrologists, this legislation appears to be a “no brainer” because a functioning transplant has been shown to be the most cost-effective form of renal replacement therapy. Cutting off payment for these drugs after 3 years seems to be a short-sighted policy. Yet there does not appear to be “traction” for this to be included in any of the “fiscal cliff” negotiations, which is about the only thing that will be addressed before the end of the current session. One can only hope that this will be included when Congress deals with Medicare reform in a more substantive way in 2013. It should be noted that if this is included, it would need to be “scored” by the Congressional Budget Office. Whether they will score this as a “cost saver” or an additional cost requiring “pay-fors” will be critical to its likelihood of success.

Innovation

There is currently no provision for new technology (both hardware and drugs/biologics) in the dialysis bundle. Technologies that can reduce costs of dialysis will, of course, be readily adopted; however, those technologies that may increase the cost of dialysis but save money overall as well as improve patient care most likely will not. For example, if one believes that more frequent dialysis decreases hospitalizations and utilization of expensive drugs over time, there is little incentive to increase the cost of dialysis because you will not realize the net savings from decreased hospitalizations and the decreased use of drugs will, at some point, come out of the base payment. As to the latter point, both the Government Accountability Office and the chair of the Medicare Payment Advisory Commission recently suggested that the CMS decrease payments to dialysis units because of the decreased use of drugs in the bundle, especially erythropoietic stimulating agents. However, if you are responsible for all of the ESRD patients’ costs as in an ACO or integrated care model, you would be able to “invest” in more expensive dialysis care if you could capture the savings from decreased hospitalizations.

As for innovative technologies that increase costs but provide better outcomes, this will be a more difficult challenge in an era when both Congress and the Administration are looking for ways to save money in entitlement programs. This is a problem that needs to be addressed as we move forward with implementation of both the bundle and the ACA.

Sustainable Growth Rate

Although it is not a part of the ACA, the sustainable growth rate (SGR) is an important component of the federal financing of health care and is an object lesson in the unintended consequences of seemingly well intentioned legislation. The SGR was part of the Balanced Budget Act of 1997 and was designed to control physician payments. Specifically, the SGR refers to the adjustment in the Physician Fee Schedule (PFS) required to meet a calculated target rate of expenditures. If the expenditures for the previous year exceeded the target expenditures, then the conversion factor would decrease payments for the next year. If the

expenditures were less than expected, the conversion factor would increase the payments to physicians for the next year. This latter event has not occurred since 2001. The problem is that each year that Congress changes the SGR, the difference between what it should have been and what is actually paid accumulates somewhat like compound interest. Therefore, the mandatory reduction in the PFS for the 2013 calendar year is 27%, which is, of course, laughable and not going to happen. The action that Congress takes to avoid the reduction is generally known as the “doc fix” and it is very expensive (\$243–\$273 billion over 10 years according to the Congressional Budget Office) (2). Although there is an obvious policy problem here, the problem for physicians in general and nephrologists in particular is that physician fees have remained relatively flat over the past several years and are likely to remain so unless there is a permanent fix to the SGR. Given the budget arithmetic outlined above, it is unlikely in the next 4 years because Congress and the Administration would have to “pay for” the \$243–\$273 billion dollar fix from either new revenues (taxes or fees) or savings from other programs. This situation is likely to further exacerbate the workforce issues described previously as more and more medical students and house staff opt to hit the “ROAD” (radiology, oncology, anesthesiology, and dermatology).

The “Bottom Line”

Under the ACA, we will see the government try very hard to get away from fee-for-service medicine. They will do this to stabilize costs and to avoid the difficulties inherent in managing patients through a regulatory process. They will let doctors, ACOs, or integrated care models manage patients in exchange for taking the financial risks (and rewards) while monitoring the quality of care provided as best they can. In nephrology this will mean increasing consolidation in the dialysis industry and increasing efforts to become more efficient and productive, which means providing the same outcomes at a lower cost. This will likely be accomplished over time with capital-labor trade-offs, such as wider use of telemedicine to monitor

patients in several dialysis units with lower credentialed providers giving “hands-on” care.

The larger number of covered lives resulting from the increased coverage under the ACA will increase the number of patients seen regularly by primary care providers and this coupled with the increase in obesity and type 2 diabetes—the US Centers for Disease Control and Prevention estimate that 20%–33% of Americans will have diabetes by 2050 (3)—will increase the number of patients with CKD. However, there will be an insufficient number of nephrologists to care for these patients using today’s care models. Nephrologists will be at the head of multidisciplinary teams to care for these patients with CKD stages “3.5” to 4.

These trends are, by themselves, neither good nor bad. Indeed, the scenarios discussed above are in place in various parts of our country today. In my judgment, the biggest challenge facing nephrology today is how to re-invigorate our profession. How do we attract the best and brightest to our specialty? If we can successfully answer that question, I have no doubt that we can meet the challenges of the future as the ACA and its inevitable future iterations come “online.”

Disclosures

R.J.R. has a consulting relationship with Amgen and has recently consulted with both DaVita and Fresenius.

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