
The Impact of State Budgets on the Kidney Industry and People with ESRD

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While the economy in the United States is improving, states continue to struggle to balance their budgets. Over the past several years, negative effects of budget reductions have been experienced by people with end-stage renal disease (ESRD) and dialysis providers. This article explores the varied reductions, their impact on people with ESRD and dialysis providers, and describes advocacy efforts. Coalitions are especially valuable in advocating for continued funding of benefits and services related to ESRD.

INTRODUCTION

Although the recession seems to be ending and the economy improving, states continue to struggle to balance their budgets. According to a state fiscal survey conducted by the National Governors Association (NGA) and the National Association of State Budget Officers (NASBO), states have implemented \$60 billion in reductions in the past two years to close their budget gaps. They have also used "rainy day" funds and have raised \$30 billion through increased taxes and fees (National Governors Association, 2010). Nearly every state implemented at least one new policy last year to help control Medicaid spending. The Kaiser Commission on Medicaid and the Uninsured produced its annual report on state Medicaid agencies, and found several common trends (Kaiser Commission on Medicaid and the Uninsured, 2011). First, some Medicaid benefits were restricted, the most common being prescription drugs, dental coverage, medical supplies, nutritional supplements, and podiatry services. Second, states implemented cost savings related to Medicaid beneficiary financial responsibilities. Nineteen states have increased copays for Medicaid beneficiaries in the last two years, particularly for prescription drugs for adults. Third, provider reimbursement rate reductions for Medicaid were common and the easiest to implement.

MEDICAID PROVIDER RATE REDUCTIONS

Provider rate reductions were the most commonly used cost containment strategy for state Medicaid programs. Provider rate reductions produce instant savings, so Medicaid providers are especially vulnerable in difficult financial times. In 2011, 13 states implemented Medicaid provider rate reductions related to payments for dialysis treatments (see Table 1). Nationally, the dialysis industry estimates that approximately 5 to 10% of Medicaid beneficiaries who receive dialysis treatments rely on Medicaid as their primary insurance and will not be eligible for the Medicare benefit. An additional 35 to 45% of Medicaid beneficiaries with kidney failure are "dual eligibles"—that is, they have Medicare as their primary insurance and Medicaid as their secondary payer. This high percentage of Medicaid beneficiaries, combined with the frequency of dialysis treatments, leaves dialysis providers at higher risk for a loss of operating revenues than other medical providers when there are Medicaid reimbursement reductions.

As a result of that payer mix, many dialysis facilities are vulnerable to operating in a negative margin, which threatens their ability to continue to provide care. Industry analysis has found that dialysis units operating in a negative margin are generally those with a higher population of individuals relying on Medicaid for their health insurance. The most vulnerable facilities could be at risk for consolidation or closure if providers experience further payment reductions. Facility closures also result in job loss and increased unemployment for the state. For dialysis patients, facility consolidations or closures could mean increased driving distances to treatments, and a change in physicians and care teams who are aware of their specific health needs. Dialysis clinics become communities of their own, which would be disrupted for both patients and staff if they close. Many, if not most, dialysis provider companies try to support vulnerable facilities in order to keep facilities where the need is high.

Table 1 shows the Medicaid provider rate reductions implemented in 2011. In each state, dialysis providers, patients, and patient organizations advocated by meeting with Medicaid officials, communicating with state legislators, and, in some states, by sending letters to the Centers for Medicare and Medicaid Services (CMS) in their oversight capacity with regard to state Medicaid programs. Meetings between state legislators and dialysis providers included local employees and focused on the negative impact to patients and communities if facilities would be forced to close. Advocates also highlighted any evidence of disproportionate impact on the industry, meaning that dialysis providers would be more impacted by cuts than other types of medical providers, due to serving Medicaid beneficiaries three times a week and having a higher percentage of Medicaid patients.

In April 2011, Texas Medicaid threatened to discontinue paying secondary Medicaid payments for all people who were dually eligible for Medicare and Medicaid. This would have represented a 20% loss of revenue from over 35% of all dialysis patients. Hundreds of letters from dialysis facility staff (including social workers) and dialysis patients were sent to state legislators. Meetings were held with Medicaid officials to educate them on the dialysis industry and the impact the cuts would have on continued operations. Dialysis patients spoke with the legislators about the negative impact on them if specific facilities would close. The

state recognized that dialysis providers would experience a more negative impact than other types of medical facilities. The final budget bill ended up including an exemption for dialysis providers, resulting in continued funding of second-

ary insurance. They did decrease the Medicaid primary and secondary payments by 5%; however, the overall payment was left intact.

Table 1. 2011 Medicaid Provider Rate Reductions to Dialysis Payments

State	Proposed Reduction and Outcome
Arizona	The Centers for Medicare & Medicaid Services (CMS) approved a 5% Medicaid primary rate reduction to providers that was passed by the state legislature; it was effective October 1, 2011. Reductions in nonemergency medical transportation were proposed, but were left intact; however, a transportation copay will begin for people who live in Maricopa and Pima counties.
California	The state legislature passed a 10% Medicaid primary rate reduction to providers, an increase in beneficiary copays, and limits to drugs and outpatient visits, effective June 1, 2011 (dialysis patients are exempt from the copays and the 7-visit limit for outpatient visits). CMS approved the 10% Medicaid reduction; a group of health providers has filed a lawsuit. The Supreme Court refused to rule, so it is back to the lower courts to decide. Nutritional supplement benefits were reduced—only beneficiaries with specific health diagnoses will qualify.
Massachusetts	The state is proposing an all-inclusive rate of \$190.74 per dialysis treatment, which includes payment for costs of all MassHealth-covered routine drugs, lab tests, home dialysis supplies, and all other dialysis-related services. It includes an add-on of \$20 per session for home dialysis training.
Minnesota	The state's proposed budget called for elimination of Medicaid secondary payments for dual eligibles since Medicare rates would exceed Medicaid rates; however, Medicaid secondary payments were preserved. The state reduced Medicaid primary rates to providers by 3%, effective September 1, 2011.
North Carolina	The state budget included a 2% across-the-board reduction to the Medicaid primary rate for all providers, beginning October 1, 2011. The reduction has been implemented.
Nevada	The governor's proposed budget included a 15% Medicaid primary rate reduction to providers, including dialysis. Dialysis providers succeeded in being included on an initial list of providers exempt from the proposed reduction. However, the governor's budget did not get accepted by the state legislature, so all providers that were exempt ended up getting the 15% reduction, effective July 1, 2011.
Ohio	The governor's proposed two-year budget plan included the elimination of Medicaid secondary payments for dual eligibles since Medicare rates would exceed the Medicaid rates. After meetings with dialysis providers, Medicaid will continue paying the secondary payments for 2011. It will be at risk in 2012.
Oregon	The governor's proposed budget initially included a 19% Medicaid primary rate reduction to providers. The state legislature passed an 11.2% Medicaid primary rate reduction to providers, effective July 1, 2011 (does not include Medicaid managed care providers).
New Jersey	The state initially proposed an all-inclusive rate of \$176 per treatment per dialysis treatment. After input from dialysis providers, the state settled on an all-inclusive rate of \$281.85 per treatment.

State	Proposed Reduction and Outcome
New York	The state implemented a 2% Medicaid primary rate reduction to providers, as of April 1, 2011. The state also proposed eliminating Medicaid secondary payments for dual eligibles, as Medicare payments would exceed Medicaid rates. New York Medicaid officials are in conversation with dialysis providers and have not yet implemented the elimination of Medicaid secondary payments.
South Carolina	The state implemented a 3% across-the-board Medicaid primary rate reduction to providers effective April 1, 2011. An additional 7% reduction was implemented July 1, 2011.
Texas	A 2% Medicaid primary rate reduction to providers was made, effective February 1, 2011. An additional 5% Medicaid primary rate reduction was implemented on September 1, 2011. The state also proposed eliminating Medicaid secondary payments for dual eligibles, but exempted dialysis providers from the reduction. A 5% reduction to Medicaid secondary payments was implemented January 1, 2012.
Wisconsin	The state moved to an all-inclusive Medicaid primary rate of \$183.70 per treatment, effective September 10, 2011, and eliminated Medicaid secondary payments for dual eligibles. After meeting with dialysis providers the state reissued its bulletin with a temporary all-inclusive rate of \$214. The state is working with providers to determine an acceptable permanent rate.

IMPLEMENTATION AND EXPANSION OF MEDICAID MANAGED CARE

States are also implementing or expanding cost savings through Medicaid Managed Care plans. Twenty-four states plan to expand or begin Medicaid Managed Care plans in 2012. States are using managed care as a way to implement quality and performance programs and for cost containment. Whereas in the past, states mainly focused on enrolling those with Medicaid as their primary insurance into new Medicaid Managed Care plans, more states are also beginning to enroll people who are dual eligibles (those with Medicare and Medicaid).

The kidney industry has seen some problems as states transition to Medicaid Managed Care either too quickly or without enough preparation. For example, in California some ESRD Medicaid beneficiaries were defaulted into managed care plans with primary care physicians who were a long distance away or who had no affiliation with their attending nephrologists or dialysis facilities. Authorization for services then had to be obtained from a physician who had no knowledge of the patient. Medicaid Managed Care plans have been slow to contract with dialysis providers in some areas or providers have been excluded from networks within contracts. The California Dialysis Council (CDC) is informing state legislators and Department of Health officials that people with ESRD have a high need for care coordination due to the following factors:

- A high rate of comorbid conditions
- The need for treatment coordination between Medicaid Managed Care plans, physician groups, transplant centers, dialysis providers, vascular surgeons and nephrologists to ensure continuity of care

- Transplantation is best for the patient and saves money for the state Medicaid program. However, those patients who are appropriate for and want to pursue transplantation have an additional need for coordination between Medicaid Managed Care plans and transplant centers.
- Transportation to dialysis treatments is vitally important and must be included as a benefit in the Medicaid Managed Care plan in a way that allows dialysis providers to work with transportation companies to ensure an appropriate level of service for this population.

The CDC is seeking to introduce state legislation this year that will allow ESRD dual eligibles a longer transition time to enroll in a managed care plan if their physician, dialysis provider, or transplant program certify that a risk to their continuity of care exists if people with ESRD enroll without necessary resources in place. Dialysis social workers have been directly involved in advocacy efforts by contacting state legislators and documenting adverse effects.

STATE RISK POOLS AND STATE KIDNEY PROGRAMS

Additional programs that have experienced negative effects of state budget reductions are state risk pools and state kidney programs. Over 30 states currently have high insurance risk pools that are administered through state funding, grants, and/or insurer assessment fees. The purpose of state risk pools is to provide health insurance to those who are unable to qualify for health insurance due to pre-existing health conditions. Washington State proposed to

eliminate its risk pool when it starts its health insurance exchange, which would provide coverage for those with pre-existing conditions in 2014. This would be a problem for dialysis patients who currently access the risk pool for Medicare supplement policies, since Medicare supplements are not offered in the new health insurance exchange programs. Washington dialysis providers and national dialysis patient organizations quickly formed a coalition to respond. Members of the coalition attended state risk pool board meetings to bring the issue to the board's attention. State legislators were contacted and asked to amend the existing legislation to allow the risk pool to continue. Through advocacy by the kidney community, the state's legislation was amended to include a study of the state's risk pool to be conducted by the end of 2012. It is hoped that, through this study, the state will decide to continue its risk pool after 2014 when the health insurance exchange is implemented.

Twenty-one states currently have state kidney programs, which exist through state funding and offer education and charitable assistance to people with kidney failure. A list is available at <http://som.missouri.edu/mokp/docs/noskp/index.html>. Some state kidney programs have seen reductions in funding or have been eliminated altogether. Missouri's kidney program received a \$1.5 million reduction in its funding during the 2011 legislative session. In March 2012, the Idaho legislature passed a bill to terminate its kidney program as of July 1, 2013. The kidney community mobilized in both of these situations and contacted legislators to raise awareness of the value of the state kidney programs. More advocacy will be done in the future to try to restore funding and programs.

ON THE HORIZON: HEALTH CARE EXCHANGES

On June 28, 2012, the United States Supreme Court released its decision on the areas of the Affordable Care Act (ACA) under its consideration. The Court ruled that the individual mandate, which requires most Americans to purchase health insurance or pay a penalty beginning in 2014, is permitted under the Constitution. The Court upheld the law in its entirety except that the Federal Government cannot deny a state's Medicaid funding if the state does not participate in the law's Medicaid expansion. Beginning in 2014, the ACA expands the Medicaid program's mandatory coverage requirements to include childless adults under age 65 up to 133% of the federal poverty level (blind, aged, disabled, and those on Medicare are excluded) (Patton Boggs, LLC, 2012).

According to the Affordable Care Act, health insurance exchanges must be ready by January 1, 2014. The exchanges are intended to be an online marketplace for health insurance. States can create their own exchanges, work with other states to create regional exchanges, or choose to have the Federal Government run the exchange for their state. The exchanges will enable people without insurance and small businesses to "shop" for insurance. Half of the uninsured will be covered by the ACA expansion of Medicaid;

applicants for insurance in the exchanges will be directed to Medicaid if they are eligible (Kaiser Health News, 2011).

Most people will continue to access health insurance through their employers, Medicare, or Medicaid. Under the ACA, those who earn less than 133% of the federal poverty level ($\$10,809.23 \times 1.33 = \$14,484$ in 2012) will qualify for Medicaid. The ACA does not address secondary insurance coverage of any kind, so exchanges do not include Medicare secondary insurance (Medigap) policies. Undocumented immigrants will not be allowed to purchase insurance through an exchange.

Those accessing insurance through the exchanges will include:

- Individuals buying their own coverage
- Employers with fewer than 100 employees (50 in some states)
- Members of Congress and their staff who will be required to buy insurance through the exchanges if they want coverage through the Federal Government

Employers with more than 100 employees may be able to access the exchanges after 2017 (Kaiser Health News, 2011).

The Congressional Budget Office estimates that, from 2016 on, between 20 million and 23 million people will use the exchanges (Congressional Budget Office, 2012). Most will be eligible for premium subsidies, at an estimated average of \$4,000 per person in 2014. Sliding scale subsidies will be available for those who earn up to 400% of the poverty level, about \$43,560 in 2011 (Congressional Budget Office, 2009). Between the existing options for insurance coverage and the new health insurance exchanges, most people will be required to have health coverage of some sort beginning in 2014.

The health insurance exchanges, like many issues these days, have become embroiled in politics. Forty-nine states (all but AK and MN) and the District of Columbia received exchange planning grants to help them establish their exchanges. Two states (FL and LA) returned their planning grants, while three states (KS, OK, and WI) have returned their early innovator grants, which were awarded to a small number of states to create health information technology systems for exchanges (Henry J. Kaiser Family Foundation, State Health Facts, 2012). The grant returns were a result of pressure from lawmakers to block implementation of the ACA. Governor Sam Brownback (KS) cited a desire for less reliance on federal assistance as a reason for returning Kansas' grant, and stated that the grant had too many strings attached (Kansas Health Institute, 2011). A federal appeals court previously ruled that Congress does not have the power to require Americans to buy health insurance. Delays in implementation of various aspects of the ACA are anticipated due to short time frames for states that have not embraced the ACA, additional lawsuits, or congressional actions that will try to delay or repeal the ACA.

HEALTH CARE REFORM AND THE KIDNEY INDUSTRY

While the kidney community did not advocate against health care reform, there are issues in the Affordable Care Act of which the kidney community should be aware. The ACA law was unclear about whether the Medicare Secondary Payer (MSP) law (defines when Medicare becomes the primary payer) would apply to individuals with employer group health coverage accessed through the new exchanges. Absent MSP, individuals who develop kidney failure would have Medicare coverage at 90 days, and therefore would be unable to participate in a group policy through the health insurance exchange. In March 2012, the United States Health & Human Services (HHS) issued its final rule on the health insurance exchanges and clarified that the MSP law will apply to group policies in the health insurance exchanges. Therefore, people who have a group policy through a health insurance exchange and then become diagnosed with ESRD have the choice to continue their policy for 30 months after becoming eligible for Medicare—just like the MSP law currently works. The kidney industry was pleased with this outcome; much advocacy had been done with HHS, the Centers for Medicare & Medicaid Services (CMS), Members of Congress, governors, state legislators, and insurance commissioners to raise awareness of this issue. Kidney coalitions in Kansas, Florida, and California wrote letters to HHS, and state legislators, insurance commissioners, and some governors wrote letters to HHS on behalf of the dialysis industry. State officials were motivated to contact HHS because if the MSP law did not apply to the health care exchanges, there could be more people accessing Medicaid for the 90-day Medicare waiting period if they could not continue to have insurance through the exchange. This would cause increased costs for the states.

Many people purchasing insurance through the exchanges will be eligible for financial assistance for their monthly insurance premiums based on their income. Those premium subsidies end when they become eligible for other health care programs, such as Medicare. If they cannot afford to continue their insurance coverage, they will default to the Medicare ESRD benefit. These changes would increase costs to the Medicare program, and dialysis providers will become even more dependent on Medicare revenue. The kidney industry is currently evaluating the most effective ways to advocate for ESRD beneficiaries to continue to have access to premium subsidies, even if they qualify for Medicare.

An important concern at the state level is the desire for adequate provider networks in the exchange plans that can meet the needs of individuals with kidney failure. All of us should watch our own state news for information about health insurance exchange development as well as opportunities to share concerns or support and to educate government health planners about the needs of those with kidney disease. These opportunities could include serving on your state's

exchange implementation committee or attending public meetings to learn more and offer your own comments.

CONCLUSION

While the outcomes have not always been successful, it is important that the kidney community continue to advocate for the insurance needs of people with ESRD, and for dialysis providers to be able to have adequate funding through benefits. Since 2003, national coalitions such as Kidney Care Partners and the Kidney Care Council have formed to advocate on federal issues. Several states, including California, Florida, Ohio, and Kansas have organized state-level kidney coalitions. In other states, short-term coalitions have formed around specific issues. These coalitions are extremely valuable as they are a way to bring the industry together around common concerns and to speak with one voice to legislators and government agencies. Social workers must continue to use their advocacy skills to speak on behalf of people with ESRD and their dialysis providers who may be vulnerable to the negative impact of state budget reductions.

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