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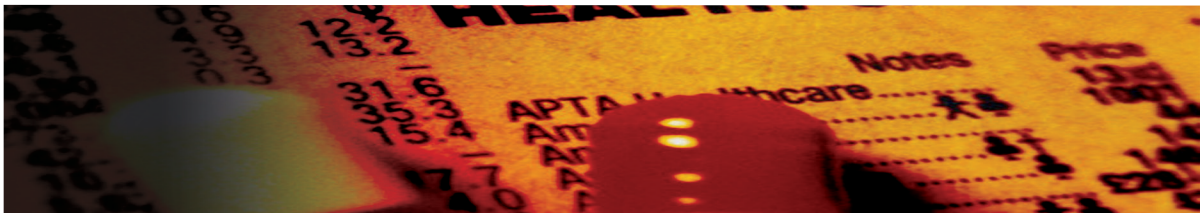
Issue 2



JUNE 2021

IN THIS ISSUE

The paper, "Safety-Net Care for Maintenance Dialysis in the United States," co-authored by Kevin F. Erickson, M.D., was published in *Journal of the American Society of Nephrology* in December 2019. Erickson is a nonresident scholar in the Center for Health and Biosciences at the Baker Institute for Public Policy, an assistant professor in the Section of Nephrology and an investigator at the Center for Innovations in Quality, Effectiveness and Safety at Baylor College of Medicine. Vivian Ho, Ph.D., the James A. Baker III Chair in Health Economics at the Baker Institute, professor of economics at Rice University and professor of medicine at Baylor College of Medicine, co-authored the article.

An electronic version of this newsletter may be downloaded at bit.ly/HPR-16-2.

Baylor College of Medicine

RICE UNIVERSITY'S BAKER INSTITUTE FOR PUBLIC POLICY

HEALTH POLICY research

Rice University's Baker Institute for Public Policy-Baylor College of Medicine
Joint Program in Health Policy Research

People with renal failure who require dialysis in the United States automatically qualify for Medicare. Is there a need for safety-net dialysis providers?

Yes, says Kevin Erickson, M.D., a nonresident scholar at the Baker Institute's Center for Health and Biosciences. Patients with end-stage kidney disease (ESKD) require expensive therapy in the form of dialysis or a kidney transplant in order to survive, and kidney failure disproportionately affects people from lower socioeconomic backgrounds. The high cost of dialysis and transplants, combined with socioeconomic disadvantage, could leave many patients with kidney failure reliant upon safety-net providers for dialysis care.

Yet unique features of Medicare's ESKD program may reduce reliance on safety-net providers. Due to federal law, most U.S. patients with ESKD become eligible for Medicare, regardless of their age. This has helped to ensure access to dialysis care for many patients who would otherwise be unable to afford it. It has also contributed to the predominance of for-profit, free-standing, dialysis facilities to meet growing demand for dialysis care, and declines in the number of hospital-based dialysis facilities.

While the majority of patients with ESKD automatically qualify for Medicare coverage, not all patients meet work and legal residency criteria. The authors examine this population of safety-net reliant patients with ESKD using a national dialysis registry to identify patients <65 years old who initiated maintenance dialysis between 2008 and 2015. Patients were considered to be safety-net reliant if they were uninsured or only had state Medicaid at dialysis onset and if they did not qualify for Medicare after starting dialysis.

The researchers found that the proportion of patients initiating maintenance dialysis in the U.S. who were safety-net reliant increased over time from 11% to 14% and varied geographically and across dialysis facilities. Among safety-net reliant patients, 73% received care at for-profit/chain-owned facilities, compared to 76% of all dialysis recipients. In adjusted models, safety-net reliant patients experienced a 2.2% *increase* in the absolute probability of dialysis at nonprofit/independently owned facilities—the vast majority of which are hospital-based. In contrast, these patients experienced 0.7%-1.5% *decreases* in the probability of dialysis at chain-owned facilities, respectively.

These findings suggest that, despite Medicare's near-universal coverage of kidney dialysis, patients with limited health insurance comprise a growing proportion of the U.S. maintenance dialysis population. Unlike other areas of health care, for-profit/chain-owned facilities are a critical part of the dialysis safety-net provider network due to their predominant role in providing outpatient dialysis care. Yet hospital-affiliated facilities provide a disproportionately high share of safety-net dialysis care.

Unlike outpatient dialysis, hospital emergency departments are required by law to stabilize all patients coming in with a health emergency, regardless of their ability to pay. Many patients who are unable to afford maintenance dialysis care end up relying on emergency departments for dialysis when they present with life-threatening complications from kidney failure. Compared to scheduled maintenance dialysis, emergency dialysis leads to worse health outcomes and higher health care expenditures. As national trends towards fewer hospital-based facilities persist, it will be critical to monitor whether dialysis chains continue to care for safety-net reliant populations or if, instead, more patients end up relying on hospital emergency departments for dialysis care.

HEALTH POLICY research presents a summary of findings on current health policy issues. It is provided by Vivian Ho, Ph.D., James A. Baker III Institute Chair in Health Economics and director of the Center for Health and Biosciences at Rice University's Baker Institute for Public Policy, in collaboration with Laura Petersen, M.D., MPH, chief of the Section of Health Services Research in the Department of Medicine at Baylor College of Medicine.

This publication aims to make research results accessible to regional and national health policymakers. The views expressed herein are those of the study authors and do not necessarily represent those of the Baker Institute or of Baylor College of Medicine.

The Baker Institute and Baylor College of Medicine's Section of Health Services Research work with scholars from across Rice University and Baylor College of Medicine to address issues of health care — access, financing, organization, delivery and outcomes. Special emphasis is given to issues of health care quality and cost.

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