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Facing a dialysis dilemma
More patients, less money create backlogs

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By Cheryl Welch
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A medical train wreck is in sight.

One train – the number of people with kidney failure – is gaining momentum. At the end of the tracks, creeping along in the opposite direction, is another train – the number of dialysis centers and the lack of financial incentive to bring more dialysis stations on line.

Unless the first train slows or shifts onto separate tracks, it will catch up and crash into the other once demand for dialysis machines outstrips supply. Among the wreckage will be patients, left waiting and wanting for life-saving dialysis treatments.

"It is a crisis," said LeAnne Zumwalt, treasurer of the Kidney Care Partners, a Washington, D.C.-based advocacy organization. "You run the risk of the program really having limited resources to treat patients and, therefore, potentially some patients may not find a center" that could take them.

"Ultimately, it's an access issue," she said.

Rising concerns

The number of people in need of dialysis is projected to quadruple by 2030 in the United States.

This estimate is based primarily on the rapidly increasing number of people diagnosed with diabetes – which can lead to kidney failure. Other factors include the longer length of time people can survive on dialysis, younger people at high risk of kidney failure and the growing obesity epidemic.

The increased need for dialysis is already evident from Centers for Disease Control and Prevention statistics. From 1980 to 2004, the number of people diagnosed with diabetes more than doubled to 14.7 million. At the same time, six times as many diabetics started dialysis treatments in 2002 than in 1984. North Carolina mirrors those trends.

"Just each year it keeps going up exponentially," said Jenny Hutto, executive director of the regional American Diabetes Association office. "I don't know if it has officially been declared an epidemic, but it certainly looks like one."

While diabetes makes up only a portion of the dialysis center population, it's the disease driving dialysis numbers and the cost of health care. In 2002, diabetes treatment accounted for $132 billion in health care spending, about one out of every 10 health care dollars. That cost is expected to increase. Unless the private, for-profit health care sector is given incentive to pick up the slack, much of the financial and manpower burden of providing emergency dialysis

treatments could be funneled to public hospitals.

The current lack of financial incentive lies mainly in the fact that federal reimbursement to dialysis centers has, according to providers, not kept pace with the demand for services.

The typical Medicare reim-bursement rate per three- to four-hour treatment is about $130. Dialysis providers say they lose about $10 on each Medicare patient seen because of the reimbursement rate.

When someone goes on dialysis – which cleanses the blood of toxins and water when the kidneys no longer can – their private insurers or Medicaid pick up the tab initially. But between month 30 and month 33, Medicare automatically takes over and becomes the primary insurer.

Nationally, about 75 percent of dialysis patients are on Medicare. Companies make up the loss and their profit margin with that initial period covered by private insurers, whose reimbursement rates are about double that of Medicare.

When you're losing money on a bulk of your patients, Zumwalt said, it makes it difficult to stay in business with the stations dialysis centers currently have and provides little motivation to add more.

"We're really strapped," she said.

Early signs

The situation is already deteriorating.

In the past few years, at least a dozen dialysis clinics have closed in rural and urban communities. Five clinics in the Washington, D.C., area were closed in July 2005 by the second largest dialysis provider – Fresenius Medical Care – because nearly all the clinics' 5,000 patients were on Medicaid or Medicare.

"They couldn't make ends meet," Zumwalt said. "I think that's a precursor of things to come over the long term."

The squeeze is even being felt locally.

DaVita Southeastern Dialysis Center, in Wilmington, is considered the mother ship of dialysis centers with 51 stations, more than double the size of a typical dialysis center. Still, it occasionally has to pull out a waiting list. The most people on the waiting list so far has been about a handful, said Susan Trynosky, facility administrator.

Slots open in the center if a patient gets a kidney transplant, or if they move, die or decide to stop dialysis. Those patients waiting for dialysis slots to open are referred to dialysis centers in Shallotte or Burgaw, both of which are an hour roundtrip for most.

“They go there until something opens here,” she said, calling the scheduling a juggling act.

Ann Robins does not consider traveling 75 miles roundtrip to Burgaw an acceptable option.

Her daughter, Katie Sumner, has been on dialysis for 18 years after a car accident destroyed both kidneys. When Sumner wanted to move back home from Seattle, Wash., to be with her parents, Robins said she was told her daughter would have to either wait or go to Burgaw or Shallotte three times a week for her blood-cleansing treatments.

“I said, ‘You’ve got to be kidding,’ ” Robins recalled. “They’re putting up buildings as fast as you can blink an eye on 17th Street and they don’t have enough space in their dialysis center?”

She investigated the options and decided it would be difficult for her daughter to be able to work and dangerous for her to drive home after her four-hour-long treatments. So Sumner waited in Seattle weeks for nine until a spot opened and she could come home.

Intercepting actions

Trynosky said her organization does the best it can to schedule everyone, but new patients take priority over those moving here.

There are no immediate plans to expand the Wilmington facility, which served the area in 1977 with 26 dialysis stations, Trynosky said. The 20-station Burgaw facility and 18-station Shallotte facility have both expanded in the past year to keep up with increasing demand and overflow from Wilmington.

Tom Gill, vice president of DaVita who oversees the company’s centers in North Carolina, said the need for stations and capacity is something he’s trying to keep up with by seeking opportunities to expand centers when the numbers add up right.

“It does cause us to work – to be a little bit aggressive in our management,” he said. “We are ahead of the train wreck. I feel very good about that.”

To keep ahead of it, though, dialysis experts say is the challenge.

According to a recent state report that lists a total of 3,360 dialysis stations, the N.C. Division of Facility Services identified a need for 174 new dialysis stations and is considering the need for another 154. Data from June 2005 suggest that about half the state’s 145 dialysis centers are operating at or above 80 percent capacity, part of the division’s criteria to expand.

To alleviate the increasing pressure on centers, Zumwalt said, legislation is needed that would automatically increase the reimbursement rate of Medicare for dialysis each year and kickstart an education campaign aimed at diabetes control and prevention.

In 2005, Congress did look into establishing a Medicare annual inflation rate for dialysis centers and how to tackle the prevention aspect.

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While the bills were never passed, Zumwalt said at least attention was brought to the issue.

“We do have some momentum going here toward our effort,” she said. “The likelihood, however, of there being Medicare legislation this year could be remote.”
Zumwalt said she hopes that with intervention “we can delay or postpone permanently” the potential dialysis crisis.

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