SUBJECT: Screening and treatment for kidney disease in the Medicaid program

COMMITTEE: Public Health — committee substitute recommended

VOTE: 5 ayes — Laubenberg, Truitt, Jackson, McReynolds, Zedler

0 nays

4 absent — Delisi, Coleman, Dawson, Solis

WITNESSES: For — Marolyn Stubblefield, National Kidney Foundation of South and Central Texas; (*Registered, but did not testify:* Syed Ahmed and Lisa Whitaker, Living Bank; Tom Banning, Texas Academy of Family Physicians; Raif Calvert, Texas Academy of Internal Medicine; Veronica de la Garza, American Diabetes Association; Greg Herzog, Texas Medical Association; Glen Maxey, Davita, Inc.; Sister Michele O'Brien, CHRISTUS Santa Rosa Healthcare)

Against — None

On — Charles Bell, Health and Human Services Commission

BACKGROUND: Medicaid, the state-federal health insurance program for low-income families, children, disabled persons, and the elderly, is administered by the Health and Human Services Commission (HHSC). It offers disease management programs for recipients with chronic health conditions such as heart disease, asthma, or AIDS.

DIGEST: CSHB 1252 would require that chronic kidney disease be added to the list of conditions for which Medicaid recipients could receive disease management services, including screening based on generally recognized clinical guidelines and laboratory assessments and treatment. If a waiver or other federal authorization were required, HHSC would be directed to obtain it.

The bill would take effect September 1, 2005.

SUPPORTERS SAY:

CSHB 1252 would ensure that patients with chronic kidney disease better manage their disease and help slow or prevent its progression into more serious kidney failure. Diabetes and hypertension are the two leading causes of chronic kidney disease. If left untreated, the damage to the filtering capabilities of the kidney can be so impaired that the patient must be placed on dialysis or require a transplant. Treatment at later stages is very expensive, and prevention can be a cost-effective way to improve patients' health.

The screening is inexpensive. A system of monitoring a patient's blood pressure, checking levels of protein in urine, and a blood test to measure creatinine all can give patients and doctors the lead time they need to implement dietary and lifestyle changes or prescribe medication. Medicaid would be treating these patients for the disease if it progressed, so the inexpensive screening would not be a cost to the Medicaid program over the long haul.

OPPONENTS SAY:

Kidney disease already is screened for in the Medicaid program because blood pressure and precursors to diabetes are monitored. Adding another statutory requirement for managed care contracts ultimately would drive up the cost of care, just as private insurers raise costs to pay for benefits mandated by the state.

NOTES:

The committee substitute would require screening based on clinical guidelines rather than specific diagnoses. It also would remove the requirement that Medicaid provide tests for complications of kidney disease.